City of Amarillo
Full-Time Employees
2027 Benefits Guide

CITY OF
AMARILLO®
OPEN SPACES ★ ENDLESS OPPORTUNITIES

January 1, 2027

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 Employee 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 Employee Benefits**
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**
Vision – Aetna Vision (Policy #268769)	1-877-973-3238 (M-Sat 6:30am to 10pm; Sun 10am to 7pm) **AetnaVision.com or Aetna Vision Preferred App**
Life Insurance and Voluntary Long-Term Disability - 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 800-368-1135 or email **ccltdsupport@standard.com** – LTD Claims 800-378-4668 or email: **CBT@standard.com** - Portability/Conversion ? **www.standard.com**
Flexible Spending Accounts – Inspira Financial	844-729-3539 (M-F, 7am to 9pm; Sat 7am to 7pm) **inspirafinancial.com or Inspira Mobile App** **Use last 4 digits of your COA Employee Number or SSN when setting up account**
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
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**
Employee Assistance Plan (EAP) – **AllOne Health**	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**
FMLA/Other Leave Requests – **United Healthcare (UHC)**	**How to Request a Leave** – Obtain a copy of the UHC flier at cityofamarillo/handbook, click Employee Benefits, under Leave of Absence. **Questions about Leave** - Human Resources Office - 806-378-4235 (M-F, 8am to 5pm); **hrfmla@amarillo.gov**
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

When Coverage Begins:

Regular, full-time employees working 40 hours per week are eligible to enroll themselves and their eligible dependents in the medical (including prescription drug coverage), dental, vision, optional life insurance and long-term disability plans effective on their **first day of employment**.

Employees who change from part-time to full-time status and meet the eligibility requirements will also become eligible to enroll in these benefit plans on their **status change effective date**.

You have **31 calendar days** from your effective date of coverage to make your elections. If there is a delay in making your insurance elections, you will be responsible for paying insurance premiums back to the effective date of coverage; therefore, it is important to enroll as soon as possible so there are no premiums in arrears due on a future paycheck.

Eligible dependents may include:

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

Documentation Required to Add Eligible Dependents to Benefit Plans

Employees may enroll eligible dependents in the City of Amarillo's medical (including prescription drug coverage), dental, vision, and legal spouse and/or children optional life insurance plans, subject to the eligibility requirements of each plan. Eligible dependents generally include a legal spouse and dependent children up to 26 years of age. This applies to new hires, status changes from part-time to full-time, mid-year qualifying life event (QLE) changes, and Open Enrollment. Examples of qualifying life events (QLEs) include marriage, birth, adoption, divorce, loss or gain of other coverage, and certain court-ordered changes.

If adding eligible dependents, dependent documentation must be provided within 31 calendar days from the event date when submitting in Workday. Failure to turn in the required documentation by this deadline will result in no coverage for the eligible dependent(s). There will be no exceptions made for failure to turn in the required documentation by the 31-calendar day deadline. Missing an enrollment deadline for a QLE means waiting until the next Open Enrollment period with a January 1st effective date.

Provided below is the required dependent documentation:

Legal Spouse (Opposite or Same Sex)	Marriage certificate/license; spouse's birth certificate; Social Security card.
Texas Common Law Spouse (Opposite or Same Sex)	Declaration of Informal Marriage or other City-accepted proof; birth certificate; Social Security card.
Biological child	Birth certificate naming the employee as parent; Social Security card.
Stepchild	Birth certificate naming the employee's spouse as parent; employee's marriage certificate/license; child's Social Security card.
Adopted Child / Child Placed for Adoption	Adoption decree or placement documents; birth certificate and Social Security card when available.
Grandchild / Child Under Guardianship	Birth certificate; Social Security card; court-issued guardianship or other legal documentation. Coverage depends on plan eligibility.

Newborns

Enroll the newborn in Workday **within 31-calendar days** from the date they are born and provide the dependent documentation noted above. A hospital certificate will not be accepted. Note: Birth certificates for children born in the State of Texas can be obtained from the Vital Statistics Department in City Hall. Birth certificates for newborns are not mailed out to the parents automatically; they must be requested with the Vital Statistics Department, and it takes up to a week from date of birth for the document to be available.

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

Qualifying Life Event

To make changes to your benefit elections you must make those changes, including providing the required dependent documentation, **within 31 calendar days from the effective date of the qualifying life event**. Failure to do so within the 31 calendar days will result in no coverage and a delay in enrollment until the next Open Enrollment period with a January 1st effective date.

Some examples of Qualifying Life Events include:

- **Changes in Household** – Having a baby or adopting a child, getting married or divorced, court-ordered dependent changes or a death of a family member.
- **Loss of Health Coverage** – Losing existing health coverage, losing eligibility for Medicare, Medicaid or CHIP, or turning 26 and losing coverage through a parent's plan.
- **Gain of Health Coverage** – Gaining eligibility for health coverage through a spouse's employer, a new employer, Medicare, Medicaid, CHIP, or another qualifying source of coverage.
- **Other Qualifying Changes** – Changes in employment status or work hours that affect benefit eligibility, or other events that result in a change in eligibility for benefits.

Employees are responsible for reporting qualifying life events and completing the required benefit changes and submitting documentation within the 31-calendar-day timeframe.

Open Enrollment

Open Enrollment is held at the end of October/beginning of November each year and the Human Resources Department will communicate what changes can be made during Open Enrollment. Open Enrollment changes are effective January 1st of the following calendar year.

Note: When requesting to add eligible dependent(s) to the insurance plans, benefit changes **will not** be processed without the required dependent documentation by the established deadlines. Qualifying life events must be submitted with the required dependent documentation within **31 calendar days from the event date** and requests made during Open Enrollment by the **imposed Open Enrollment deadline**. No exceptions will be made for failure to submit the request and/or required dependent documentation by the required deadlines.

2027 Healthcare Insurance
Employee Premiums (Per Pay Period)

MEDICAL PREMIUMS

Medical Plan 1	Medical Plan 2
Employee Only - $26.34	Employee Only - $28.97
Employee and Spouse - $84.44	Employee and Spouse - $101.32
Employee and Child(ren) - $71.46	Employee and Child(ren) - $85.75
Employee and Family - $134.86	Employee and Family - $161.83

DENTAL PREMIUMS

Dental Plan 1 (Low Plan)	Dental Plan 2 (High Plan)
Employee Only - $19.37	Employee Only - $21.30
Employee and Spouse - $36.51	Employee and Spouse - $40.17
Employee and Child(ren) - $34.08	Employee and Child(ren) - $37.50
Employee and Family - $51.12	Employee and Family - $56.23

VISION PREMIUMS

Vision Plan
Employee Only - $2.67
Employee and Spouse - $4.99
Employee and Child(ren) - $5.06
Employee and Family - $7.81

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):

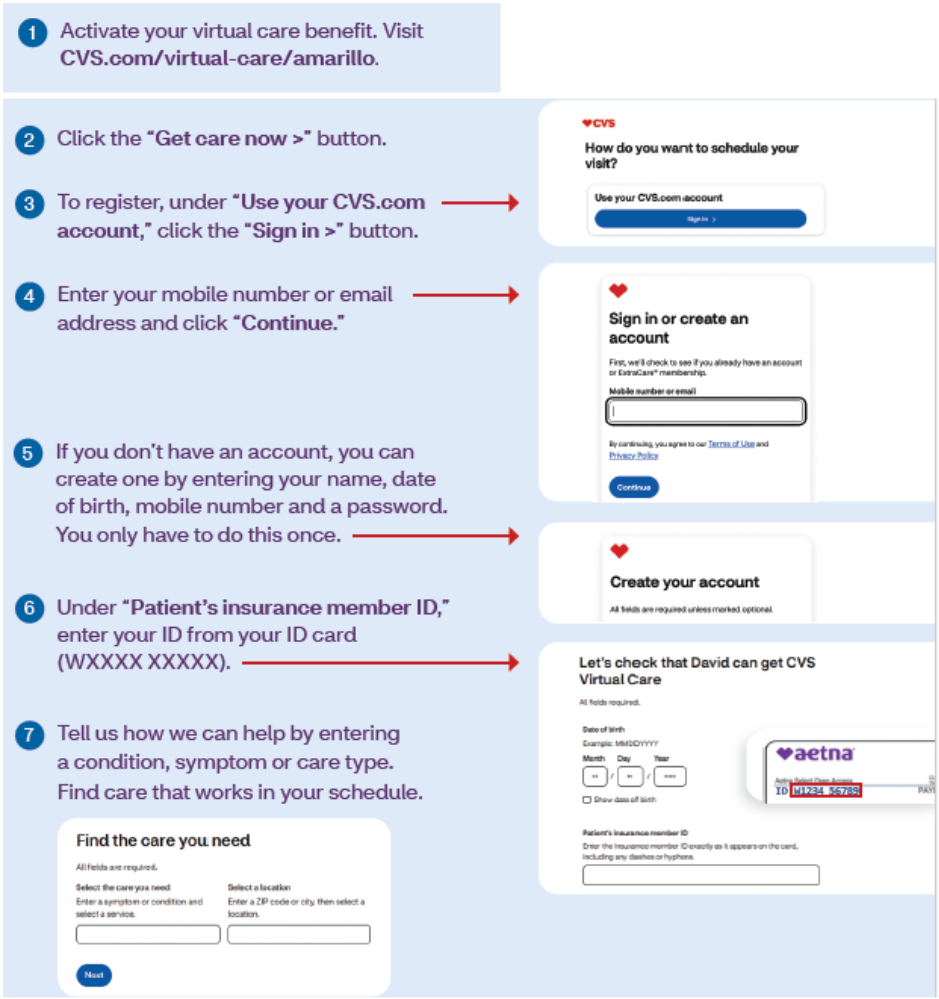
- Consult with a licensed therapist for mental health services and get help with medication management.

Additional Benefits:

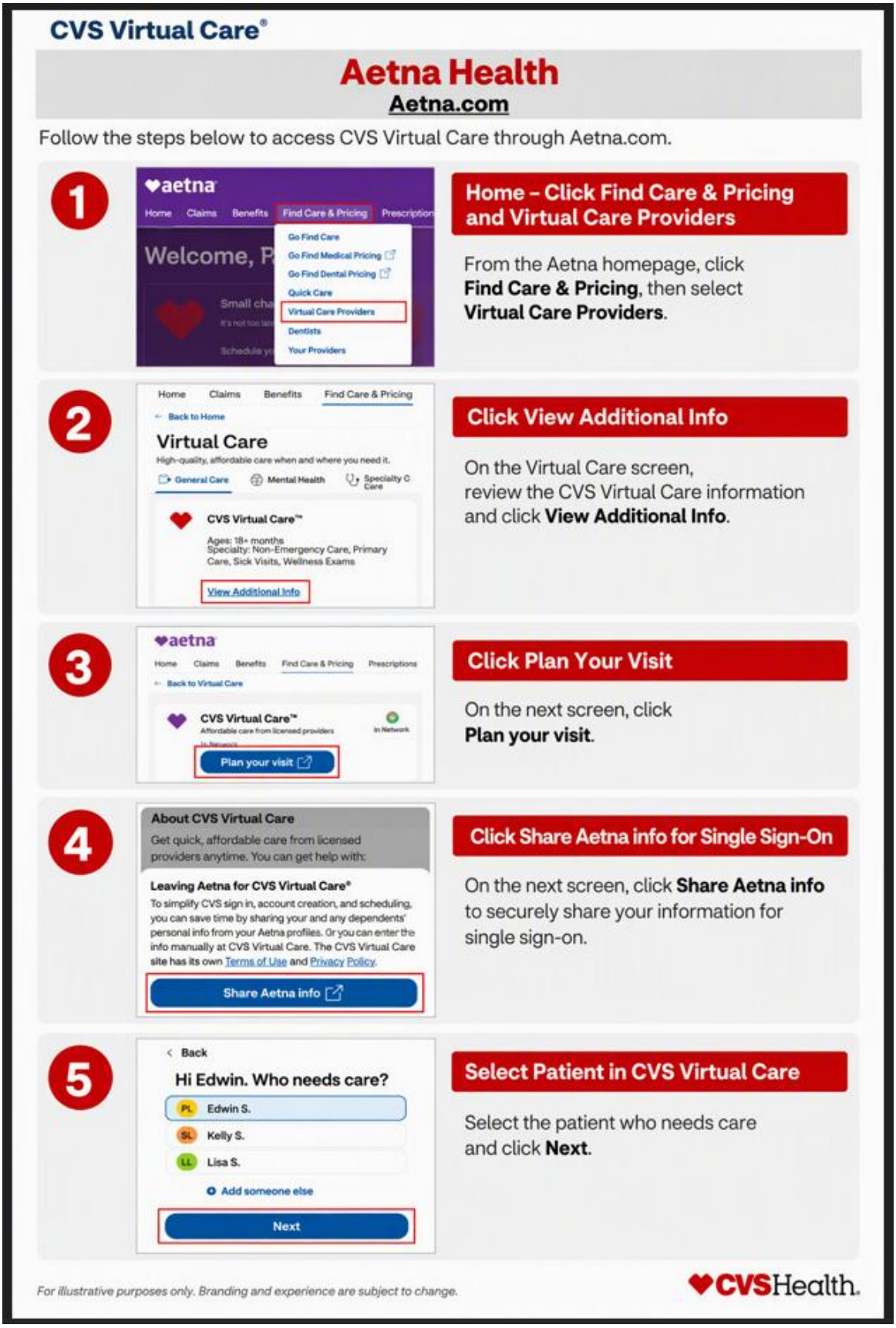
- When in person follow up care is needed, CVS will help coordinate those referrals with in-network providers.
- Access to your personal health information and lab results is available through the health dashboard.

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.

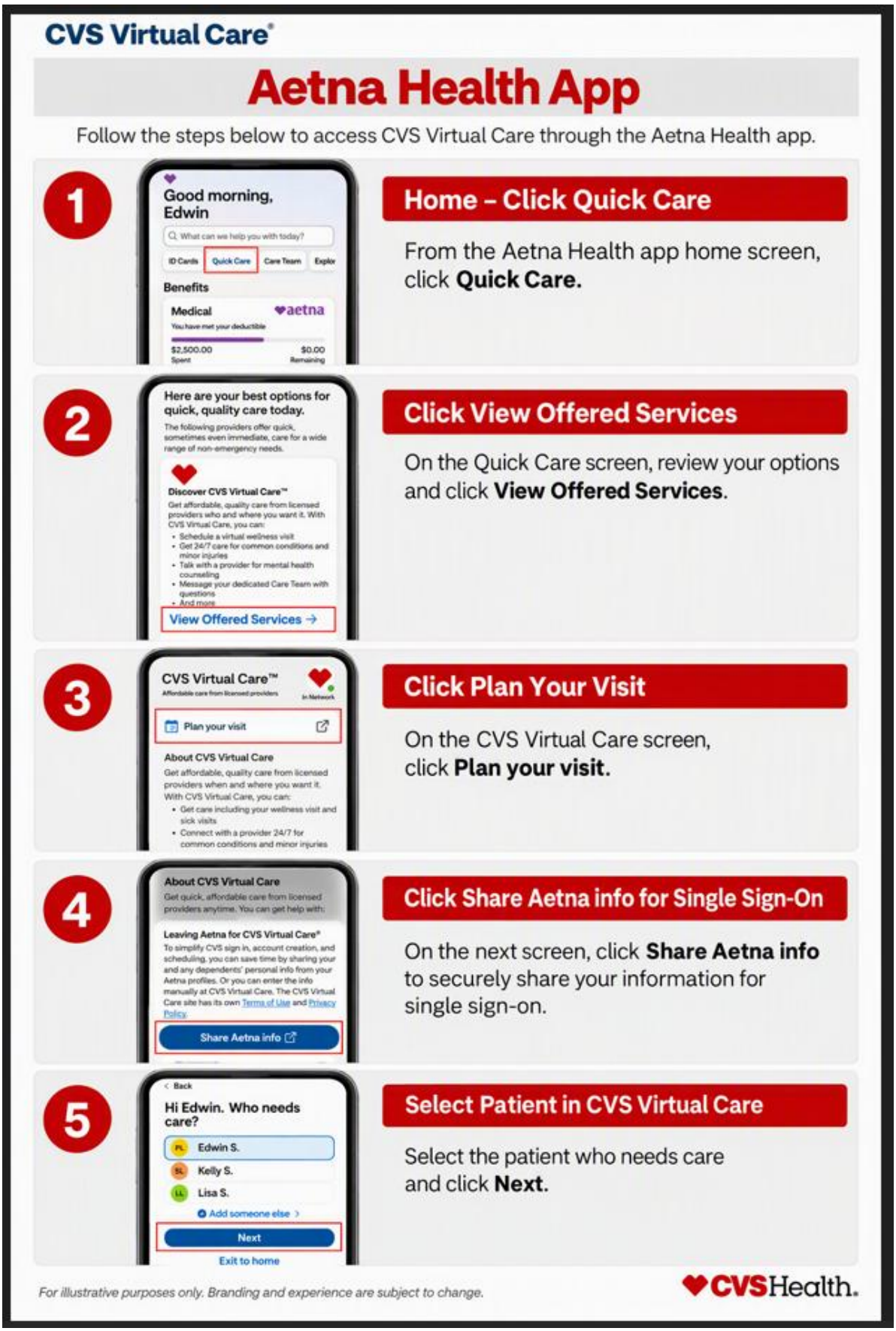
Provided below are the instructions on how to access the website through CVS.com/virtual-care/amarillo:



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, co-pays 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 Employee Benefits and is located under the Pharmacy section.

Dental Plans

The Dental Plans will provide you and your family with coverage for typical dental expenses such as cleanings, x-rays, and fillings. The dental plan is provided through **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: 1/1/2027

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	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: 1/1/2027

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 Adults and Dependent Children	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.

Dental Information

Delta Dental Networks (Continued)

- 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**.

Vision Plan

The Vision Preferred Plan is administered by **Aetna Vision using the EyeMed network**. You will save money by utilizing in-network providers. Lens coverage can be used for eyeglasses or one order of contact lenses, but not both.

Aetna Vision℠ Preferred

Summary of Benefits for City Of Amarillo

Effective Date: 01/01/2027 Frequency (Exam/Frame/Lens): 12/24/12 Enhanced Plan-WAL Current Vision Plan 988283 - Package A	In Network Member Cost Aetna Vision Network	Out of Network Member Reimbursement*
Exam		
Eye Exam with Dilation as Necessary	$0 Copay	$35 Reimbursement
Retinal Imaging	Member pays discounted fee of $39	Not Covered
Standard Contact Lens Fit /Follow Up[1]	Member pays discounted fee of $40	Not Covered
Premium Contact Lens Fit /Follow Up[1]	10% off retail price	Not Covered
Frames		
Any Frame available, including frames for prescription sunglasses	$0 Copay; $150 Allowance**, 20% off balance over allowance	$75 Reimbursement
Standard Plastic Lenses		
Single Vision	$0 Copay	$25 Reimbursement
Bifocal	$0 Copay	$40 Reimbursement
Trifocal	$0 Copay	$55 Reimbursement
Lenticular	$0 Copay	$55 Reimbursement
Standard Progressive Lens (copay includes bifocal cost)	$65 Copay	$40 Reimbursement
Premium Progressive Lens Tier 1 (copay includes bifocal cost)[2]	$85 Copay	$40 Reimbursement
Premium Progressive Lens Tier 2 (copay includes bifocal cost)[2]	$95 Copay	$40 Reimbursement
Premium Progressive Lens Tier 3 (copay includes bifocal cost)[2]	$110 Copay	$40 Reimbursement
Premium Progressive Lens Tier 4 (copay includes bifocal cost)[2]	$175 Copay; 80% of Charge less $na allowance	$40 Reimbursement
Lens Options		
UV Treatment	Member pays discounted fee of $15	Not Covered
Tint (Solid And Gradient)	Member pays discounted fee of $15	Not Covered
Standard Plastic Scratch Coating	Member pays discounted fee of $15	Not Covered
Polycarbonate Lenses - Adult	Member pays discounted fee of $40	Not Covered
Polycarbonate Lenses - Children to age 19	Member pays discounted fee of $40	Not Covered
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Premium Anti-Reflective Coating Tier 1[2]	Member pays discounted fee of $57	Not Covered
Premium Anti-Reflective Coating Tier 2[2]	Member pays discounted fee of $68	Not Covered
Premium Anti-Reflective Coating Tier 3[2]	Member pays discounted fee of $85	Not Covered
Photochromic/Transitions Plastic - Adult	Member pays discounted fee of $75	Not Covered
Photochromic/Transitions Plastic - Children to age 19	Member pays discounted fee of $75	Not Covered
Other Add-Ons	20% off retail price	Not Covered

Contact Lenses		
Conventional	$0 Copay; $150 Allowance**, 15% off balance over allowance	$120 Reimbursement
Disposable	$0 Copay; $150 Allowance	$120 Reimbursement
Medically Necessary	Covered in Full	$200 Reimbursement

Frequency	Children to age 19	Adults age 19 and over
Exam	once every Calendar Year	once every Calendar Year
Frame	once every two Calendar Years	once every two Calendar Years
Lenses	once every Calendar Year	once every Calendar Year
Contact Lenses	once every Calendar Year	once every Calendar Year

Lens Coverage can be used for eyeglass lenses OR 1 order of contact lenses

In Network Discounts	
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands	
Additional pairs of eyeglasses or prescription sunglasses[3]	**Up to 40% off prescription eyeglasses/sunglasses and 15% off conventional contact lenses once the funded benefit has been used**
Non-covered Items[4]	**20% off retail price**
Lasik Laser vision correction or PRK from **U.S. Laser Network**[5]. Call 1-800-422-6600	**15% discount off retail price or 5% discount off promotional price**
Hearing Discounts[6] - two ways to save: **Hearing Care Solutions** 1-866-344-7756 **Amplifon Hearing Health Care** 1-877-301-0840	**Save on hearing aids, exams, batteries, repairs and more**

Partial list of exclusions and limitations

Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.

*Out of network coverage is available. To receive reimbursement up to the amounts listed above, a claim form with itemized receipt is required. Reimbursement will not exceed the providers actual charge. Claims forms can be found at aetnavision.com or by calling customer service Monday through Sunday at 1-877-973-3238. Completed claim forms can be submitted electronically or mailed to Aetna, PO Box 8504 Mason, OH 45040-7111. You also have access to Allied Providers, such as Costco Vision, who will apply your out-of-network benefits at the point of service and handle the claim submission process for you.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

[1]Contact lens fit and two follow-up visits are allowed once an eye exam has been completed.

[2]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information. Premium Progressive Lens cost includes bifocal cost.

[3]Additional pair discount applies to purchases made after the plan allowances have been exhausted. Discounts are not insurance.

[4]Non covered discounts may not be available in all states.

[5]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

[6]Aetna does not endorse any vendor, product or service associated with these discount offers. Vendors are independent of Aetna, not agents or employees. Programs, products and services may not be available at all times. Certain offers may not be available in some states. Products and services are provided by Hearing Care Solutions and Amplifon Hearing Health Care (formerly HearPO).

Policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. These are the plan's main exclusions and limitations. See the booklet-certificate for a complete description. The plan does not cover: special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (nonprescription) lenses; nonprescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses.

Providers in the Aetna Vision network are contracted and credentialed through EyeMed Vision Care, LLC according to EyeMed's requirements. EyeMed and Aetna are independent contractors and not agents of each other. Provider participation may change without notice.

Refer to Aetna.com for more information about Aetna® plans.

Vision Information

- **Vision Card** – Two family vision cards will be mailed to your home address as listed in Workday. You can access, print additional cards, download your card to your digital wallet, and request a replacement card via the Aetna Vision Website or Aetna Vision Preferred App. Included with your ID card will be a list of 10 in-network vision providers that are located closest to your home zip code. Should you not have your card available upon visiting a vision provider, you are able to provide your name and date of birth for vision coverage confirmation.
- **Aetna Vision Preferred App** – The Aetna Vision Preferred App allows you to check benefits, track claims, find in-network vision providers, receive contact lens replacement and upcoming exam reminders, and obtain a digital ID card. Download the App and register using your Member ID. If you have already registered an account on the **AetnaVision.com** website, you can log onto the App using the same account information.
- **AetnaVision.com** – If you have not set up an account, you may register using your member ID or using your social security number.
- **Aetna Vision Preferred Network** – Aetna provides the right mix of in-network providers using the EyeMed network nationwide and online. Go to **AetnaVision.com**, select **Find a Provider** to start searching for in-network providers.
- **Cost Estimator** – Register or log into your account at **AetnaVision.com** and click the Estimate Costs tab to get a clear summary of your estimated out-of-pocket costs based on your selections.
- **Online Shopping Available** – Online shopping is available through Lenscrafters.com, TargetOptical.com, Ray-Ban.com, Glasses.com, ContactsDirect.com, BeFitting.com, and Oakley.com. Your plan benefits will be automatically applied at checkout.
- **Extra Discounts** – Special offers are available at **AetnaVision.com** and the Aetna Vision Preferred App. Get up to 40% off an extra pair of eyeglasses, 20% off non-prescription sunglasses and accessories, and discounts on LASIK laser vision correction, plus other exclusive special offers.

Life Insurance

The Standard Insurance Company "The Standard" is the vendor for our life insurance plans. On date of hire or on the status change date from a part-time to full-time position, employees are automatically enrolled in the $10,000 Employee Basic Life Insurance and Accidental Death & Dismemberment (AD&D) benefit that is paid **100% by the** City. Additional Life Insurance is available for yourself, your legal spouse and/or dependent children (through 25 years of age). These premiums are paid by the employee and deducted from your paycheck on a post-tax basis. Information is provided below regarding the insurance plans available to you.

Type of Coverage	Coverage
Employee	**Employee Basic & Additional Life Insurance** ○ $10,000 Basic Life Insurance with AD&D – **EMPLOYER PAID** ○ Additional Life Insurance with AD&D – **EMPLOYEE PAID (POST-TAX)** ○ $10,000 up to $500,000 (in $10,000 increments) ○ Additional Employee Life Insurance cannot exceed 8 times your Base Annual Earnings (rounded down to the next $10,000 of coverage). Example: $34,000 x 8 = $272,000. Rounded down to next $10,000, maximum coverage allowed is $270,000. ○ Premiums elected will be based on your age as of January 1st of the current calendar year. ○ No Evidence of Insurability (EOI) is required for amounts elected up to $250,000. If eligible, and electing coverage above $250,000, you will need to complete EOI. You will then pay premiums on the $250,000 beginning with your date of hire or status change date. Note, if you are a late entrant, EOI is required for any amount. Evidence of Insurability (EOI) Information ▪ **What is EOI?** Evidence of Insurability is documented proof of good health. An employee begins the EOI and medical underwriting process by submitting a Medical History Statement. This, along with other information obtained during the underwriting evaluation, is used by the Standard to make the underwriting determination. ▪ **How do I apply for EOI?** You will receive an invitation to apply from the Standard. The invitation will be sent to your work email address and will include a secure online link and login instructions. If a work email address is not available, you will be mailed an invitation to your home address. ▪ **What information do I need to complete my EOI?** 1. Before starting the application, make sure you have recent diagnoses, physician and treatment details accessible. 2. Personal demographic information 3. Group Name (City of Amarillo) and Policy Number (646089). 4. The amount above the guaranteed amount of $250,000 is what you will be requesting for approval. For example, you elected $300,000, $50,000 is the amount to be provided in your EOI application. ○ The deadline to submit EOI is 31 calendar days from your date of hire or status change date. ○ The Standard Insurance Company may request additional medical, testing, bloodwork, etc., during the EOI process. Each EOI is reviewed on an individual basis, and the medical underwriters would request additional information if needed. The Standard will pay for additional testing if required. ○ Notification of your approval or denial of EOI will be provided by the Standard both to the employee and the Human Resources Department. If approved, your premiums will increase based on the amount approved and in the pay period that covers the approval date.

Legal Spouse	**Spouse Additional Life Insurance**
	• Additional Life Insurance with AD&D – **EMPLOYEE PAID (POST-TAX)**
	  ○ $10,000 up to $50,000 (in $10,000 increments)
	  ○ No EOI is required for any amounts elected.
	  The total combined coverage that includes your employer paid Basic Life Insurance coverage of $10,000 and Employee Additional Life Insurance must be equal to or greater than your spouse's coverage.

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

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

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

Updating Life Insurance Beneficiaries

You can update your life insurance beneficiaries anytime throughout the year through Workday. Instructions for Creating New or Existing Beneficiaries in Workday can be found at cityofamarillo/handbook, click on Employee Benefits, under Life Insurance.

Voluntary Long-Term Disability (LTD)

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

A summary of this benefit is provided below:

- **Continuously Disabled for 90 Consecutive Days -** Before you become eligible to receive a monthly benefit.
- **If Approved for LTD** - You will receive 60% of your eligible earnings, up to a maximum benefit of $12,500 per month.
- For a continuous disability, your benefits may last until your Social Security Normal Retirement Age depending on your age at time of disability. If you become disabled before age 62, LTD benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years, 6 months, which is longer. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins.
- **Deductible** Income - Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to receive while receiving LTD benefits. Some examples of deductible income include sick or annual leave pay and/or benefits being received under workers' compensation.
- If you enroll in the voluntary long-term disability benefit at time of hire or status change to full-time, your first premium deduction will be reflected on your first paycheck or the paycheck that covers your status change effective date.

- If you feel that you may have a qualifying disability where you will be out more than 90 consecutive calendar days, it is suggested that you begin the disability claim process after 30 days of your disability. Contact the Human Resources Department for any questions about this benefit.
- Changes to your premiums due to age bracket changes from the previous calendar year (January 1st through December 31st) will be updated automatically in Workday. These changes will be reflected in the first paycheck received in January. Your LTD premiums will then increase the following year based on your age bracket change.

Flexible Spending Accounts (FSA)

Inspira Financial is the vendor for Flexible Spending Accounts for Health Care and Dependent Care. With an FSA, you set aside pretax earnings to pay for eligible health and dependent care expenses. That adds purchasing power because the money you would have paid in taxes is available for you to spend. You can enroll in one or both FSA plans. A list of eligible expenses can be found on the **inspirafinancial.com** website.

What is a Health Care Flexible Spending Account (HCFSA)?
Eligible health care expenses include copays, coinsurance, and deductibles; dental and vision expenses; prescriptions and over-the-counter health care supplies from select retailers for yourself, your legal spouse, and eligible children.

A Debit Card will be automatically mailed to new enrollees in the HCFSA plan only and can be presented at point of sale in place of submitting a claim.

How much can I contribute to my HCFSA?
The minimum you can contribute is $100 and maximum is $3,400.

What is a Dependent Care Flexible Spending Account (DCFSA)?
Pay for eligible child and adult care expenses, such as day care, preschool and nursery school, in-home aid, and more. Funds are for your dependent(s) age 12 or younger or a spouse or dependent incapable of self-care. You must be working or looking for work to use your dependent care funds. If you're married, your legal spouse must either be working, looking for work, or a full-time student.

How much can I contribute to my DCFSA?
The minimum you can contribute is $100. Your contribution maximum limit is determined by your tax filing status. Married Filing Separately is $3,750 and Single, Head of Household, or if Married Filing Jointly is $7,500.

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

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

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

- **Inspira Debit Card for Health Care FSA**
  Use your Inspira Debit Card for a health care expense and it will be paid automatically from your FSA account. Save receipts and explanation of benefits (EOB) in case you need to substantiate a purchase.
    - Keeping your Debit Card Active – The IRS requires Inspira to verify that debit card purchases are eligible expenses so you may need to provide documentation for a card purchase. Keep copies of detailed receipts or explanations of benefits (EOBs) in case verification is required.
    - Email Notifications - Sign up to receive email notifications so you will know right away when documentation is needed. Log into the Inspira website, click your name in the top right and select communication settings.
    - Ways to Submit Documentation – Log into the Inspira website. Go to My Claims, then Claim Activity and click Add Receipt.
- **Inspira Mobile App** – Download the App and log into your account. Then, just snap a picture of your itemized receipt and submit a claim via the App. You can also access your balance and account statement. This is the easiest way to manage your account and view alerts, submit claims, and use the barcode scanner to verify eligible items in-store.
- **Inspira Online** – Sign into your online account to submit a claim. Go to **inspirafinaancial.com** to see your account statement and balance, submit claims, sign up for email, text alerts and direct deposit.

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

Grace Period
There is a grace period allowed under both FSA Plans. The grace period lets you spend or use remaining funds from the prior calendar year on new eligible expenses. The run-out period lets you file claims from the previous year. You must file your claims (even those from the grace period) by the end of the run-out period (e.g., March 31st).

Example (Calendar Year Plan):
- **Plan Year:** Jan 1 - Dec 31.
- **Grace Period:** Jan 1 - Mar 15 (for new spending).
- **Run-Out Period:** Jan 1 - Mar 31 (to submit claims for Dec 31 or earlier spending).

Pension Benefits

Texas Municipal Retirement System (TMRS)

The Texas Municipal Retirement System (TMRS) is a retirement pension program for eligible City employees, including civilian employees and police officers. Eligible employees are automatically enrolled in TMRS when they are hired or when they become eligible due to a change in employment status.

Employees contribute **7% of their gross compensation** each pay period on a pre-tax basis and your employer will make a 19.82% matching contribution. Employee contributions are required and cannot be stopped while employed in an eligible position.

Vesting and Service Credit
Employees become vested with TMRS when you accrue five total years of service credit. You earn one month of service credit for each month you make a required contribution while employed in an eligible position.

If you leave TMRS-covered employment:

- **Vested members**: You may leave your deposits, including employee contributions and employer matching contributions with TMRS. Your account will continue to earn annual interest credits until you retire.
- **Non-Vested Members**: You may leave your employee contributions with TMRS up to five years, and they will continue to earn annual interest credits during that time.

Service Credit

Service credit from other statewide retirement systems or eligible governmental entities (includes active military duty service) may also count toward your TMRS retirement eligibility. Combining service credit may allow you to qualify for retirement sooner. Contact TMRS for more information about prior service credit.

Retirement Eligibility

To qualify for a TMRS pension annuity, you must meet one of the following requirements:

- 20 years of service credit at any age;
- Age 60 with at least five years of service credit; or
- Approval for disability retirement through TMRS.

Your TMRS Account

TMRS will mail an information packet to your home address on file. You will need to establish your TMRS account online at **www.tmrs.com** or through the TMRS App and designate your beneficiaries.

Be sure to keep your name, address and beneficiary information up to date with TMRS. Once you have five years of service credit, TMRS will require you to update your beneficiary information.

Planning for Retirement

If you are planning to retire, we recommend scheduling an appointment with the Human Resources Department **within 30 days of your planned retirement date** to review the retirement process and required steps.

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

Amarillo Fireman Relief and Retirement Fund (AFRRF)

Under the Texas Local Fire Fighters Retirement Act (TLFFRA), City of Amarillo Firefighters are provided with a retirement benefit. As provided under TLFFRA, all firefighters must be less than 36 years of age upon entering service for the City as a firefighter and must become members of the Plan. This Plan provides pension, death, and disability benefits. This Plan covers current and former firefighters, as well as beneficiaries of current and former firefighters. Firefighters will need to refer to the AFRRF for retirement eligibility requirements. Contact the Finance Department regarding any questions about the AFRRF.

Other Retirement Plans

457 Deferred Compensation Plan through Nationwide

This plan provides an additional opportunity for employees to save money for retirement under the 475 Deferred Compensation Plan through Nationwide by contributing pre-and post-tax dollars into a retirement account. Provided below is the information you will need to enroll, make contribution or investment changes, or change your address/beneficiary information with the City of Amarillo's 457 Deferred Compensation Plan with Nationwide.

Nationwide 457 Deferred Compensation Plan – Log into your account at www.nrsforu.com

- **Enrollment Options**
  - Enroll Online for the first time
    - ✓ Go to www.nrsforu.com. Go to LOGIN Help & Sign up (on the Nationwide Main Page). Select Texas from the drop-down menu and search for "City of Amarillo." If you need assistance through these screens, you can call Nationwide Customer Service at 1-877-677-3678.
    - ✓ Enroll by Text to 877697 and type in Ready.
  - Schedule an Appointment with our Nationwide Lubbock Representative – Jim Hammock
    - ✓ Telephone Number: 1-806-441-6069
    - ✓ Email: hammj25@nationwide.com
  - Call Nationwide Customer Service
    - ✓ Telephone Number: 1-877-677-3678. M-F, 7am to 10pm CST and Saturday, 8am to 5pm CST.
- **IRS Contribution Limits**
  - $24,500 is the maximum yearly contribution.
  - If age 50 or older, an additional contribution of $8,000 is allowed for a total annual amount of $32,500.
  - If you are 60 through 63 years of age in 2026, an additional contribution of $11,250 is allowed for a total annual amount of $35,750.
- **Changes to your Contribution Amounts**
  - Online at www.nrsforu.com (after you enrolled online for the first time).
  - Call Nationwide Customer Service at 1-877-677-3678.
  - Contribution changes will be effective at the beginning of the first available pay period after receiving the contribution change from Nationwide.
  - Automatic Contribution Feature – This feature allows you to increase your contribution automatically by a percentage of your choice each year. Go to "Manage Account", select "Automatic Contributions Increase," then "Manage Automatic Increase." Then scroll down and provide the necessary information to set up this feature.
- **Changes to your Investments**
  - Online at www.nrsforu.com (after you enrolled online for the first time).
  - Call Nationwide Customer Service at 1-877-677-3678.
- **Address/Name Change**
  - Address/Name Changes – Once updated in Workday, address and name changes are electronically transferred to Nationwide.
- **Beneficiary Changes**
  - Log into your Nationwide account.
  - Select "View Account" and Click on Beneficiaries. Click on "Manage Beneficiaries." Designate Primary and Secondary Beneficiaries so the allocations total 100%.

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

- ✓ You must be enrolled in the 457(b) Deferred Compensation Plan through Nationwide with the City to be eligible to enroll in this benefit.
- ✓ The Special 457 Catch-Up is available during the last three taxable years ending before the taxable year in which the participant attains Normal Retirement Age. A participant may not use the age 50 catch-up in any taxable year in which the Special 457 Catch-Up is used. After the three-year period, the age 50 Catch-Up may resume for participants who remain eligible.
- ✓ For general employees, Normal Retirement Age may be designated between age 55 and age 70-1/2. For qualified police officers and firefighters, it may be designated between age 40 and age 70-1/2.
- ✓ If you are interested in finding out more about this benefit, contact Nationwide customer service at 1-877-677-3678, M-F: 7am to 10pm and Saturday 8am to 5pm CST.

Other Benefits/Information

AFLAC

Employees have the opportunity to enroll in AFLAC's supplemental insurance policies for Short-Term Disability, Cancer, Accident, Hospital and Critical Care. Contact the local AFLAC representative any time throughout the year to enroll in any of these policies. The insurance premiums are 100% paid by the employee post-tax through payroll deduction. Visit **aflac.com/myaflac** or download the MyAflac mobile app to register and log into your account. Once registered, you can enroll in claims direct deposit and file an AFLAC SmartClaim to get paid quickly and track the status of your claim. AFLAC location in Amarillo: 5901 S. Bell Street, Suite C-24, Amarillo, TX 79019.

Employee Assistance Program (EAP)

Your mental health and well-being matters. The City offers an Employee Assistance Program as one of our benefits, providing mental health counseling and a wide range of whole health support services for all employees and anyone living in your household starting on your first day of employment.

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!

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

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

- **Beneficiary Changes**
  - Basic Life Insurance provided by the Employer and Optional Employee Life Insurance – Updated in Workday.
  - Nationwide 457 Deferred Compensation
    - Log into your account at **www.nrsforu.com**.
    - 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.

Active Employees – Considering Future Retirement

Via Benefits through Towers Watson offers a free service to help employees plan for retirement and understand health insurance options during retirement, including Medicare. For more information, call Via Benefits Customer Service at 1-855-803-2540, M-F, 7am to 8pm CST or by visiting their website at **https://my.viabenefits.com/discover/**.

Future Retiree Benefits

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

Pre-65 Retiree Medical/Dental

You must be enrolled in the City's medical and/or dental plans at the time of retirement to be eligible for this benefit. Only dependents (legal spouse and eligible children) enrolled in these plans prior to retirement are eligible to enroll in the pre-65 medical/dental plans. If an employee retires and elects the pre-65 medical/dental plans there will be no lapse in coverage moving from the active to the pre-65 medical/dental plans. Retiree medical premiums are based on your full years of service with the City of Amarillo (i.e., you have 12 years and 6 months of service at time of retirement, your premium will be based on 12 years of service). Your pre-65 medical (includes prescription) and dental benefits will end the last day of the month prior to the month you turn 65 years of age. The only exception is if your birthday falls on the 1st of the month, Medicare then begins the 1st of the previous month you turn 65 years of age (i.e., July 1st birthday, Medicare begins June 1st). Once the retiree or retiree spouse turns 65 years of age, they will transition to enrollment in Medicare and be eligible to participate in the post-65 retiree benefit offered through VIA Benefits. The children will automatically be dropped from coverage at the end of the month when the retiree or spouse turns 65 or when the child turns 26 years of age (whichever comes first).

Health Reimbursement Account (HRA) Sick Leave Benefit

At time of retirement, Civilian, Police Officers, and 8-hour Firefighters will be allowed to convert any available sick leave, above 90 days of sick leave (720 hours) paid at 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. 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 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.

Retiree/Spouse Life Insurance

Retirees are eligible to elect a $5,000 or $10,000 life insurance policy on themselves at time of retirement. A retiree spouse life insurance policy is available in the amount of $5,000 only if the retiree elects the $10,000 policy for themselves. If you enroll in the retiree life insurance, you can still convert your active life insurance into a whole life insurance policy. If the retiree chooses not to enroll in the retiree life insurance, the retiree can port their life insurance to a term life insurance policy. When converting or porting your active life insurance, you must contact the life insurance provider within 31 calendar days from the date of retirement.

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 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 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. It can be cashed out and taxed accordingly if taking lump sum option or if enrolled in the 457b Deferred Compensation plan you 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. It can be cashed out and taxed accordingly if taking lump sum option or if enrolled in the 457b Deferred Compensation plan you 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 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.

Sick Leave Rollover

Employees that are within 3 years of retirement eligibility and have the required amount of accrued sick leave at time of request may be eligible for the 457 Deferred Compensation rollover option. Civilian employees are eligible for this benefit only if they were hired prior to October 1, 2007. Firefighters and Police Officers are eligible regardless of their hire date. All employees, except for 12-hour firefighters, must have at least 816 hours accrued sick leave hours at time of request. Twelve-hour firefighters must have 1224 hours. Non-firefighter employees that are 57 years of age and are within 3 years of retirement eligibility must have 576 hours accrued sick leave hours at time of request.

Key information about this program is provided below:

- ✓ Employees must have a 457 Deferred Compensation account open at the time of their request.
- ✓ Employees must sign up each year if they want to participate in the program once their 3-year period begins.
- ✓ Employees are only eligible to participate in this 3-year program once during their employment with the City of Amarillo.
- ✓ Employees are only eligible for this benefit for a 3-year period that starts with the first year of the election. If the rollover is elected the 1st year and the employee chooses not to participate the following year (2nd year), they are eligible to participate in the 3rd year. All other employees, except for firefighters, can rollover 240 hours at their base hourly rate each year during their continuous 3-year period into their City of Amarillo's Deferred Compensation Account. 12-hour firefighters can rollover 360 hours each year.
- ✓ A firefighters rollover amount will be determined based on their current shift worked at time of rollover (i.e., 8 hr. or 12 hr. firefighter).
- ✓ Required sick leave hours must be met in the first year you are participating, and twelve (12) days of sick leave must remain in your sick leave account after the rollover.
- ✓ Elections are irrevocable once elected and cannot later be used as compensable sick time.
- ✓ Participation cannot occur during the year you plan to retire with the City of Amarillo.
- ✓ Sick leave eligibility is based on years of service with the City of Amarillo.
- ✓ Sick Leave Rollover funds will be deposited into a pre-tax 457 account with Nationwide. If you are currently contributing to a post-tax Roth account, 100% of the Sick Leave Rollover funds will be deposited into a pre-tax account regardless of your current elections.
- ✓ If you are currently contributing to the 457 Deferred Compensation plan and your Sick Leave Rollover amount will exceed the IRS limit you are eligible for based on your age at time of distribution, you will not be able to participate in that calendar year. If you started your 3-year period and are not eligible due to this reason, this will forfeit your opportunity to enroll that calendar year.
- ✓ The Human Resources Department will send out communications to eligible employees each year.

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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