JEFF WAGNER

MAYOR

# 2025 Benefits Guide

# City of Pasadena, Texas

# Table of Contents



If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please refer to your Medicare Part D Non-Creditable Coverage Notice on pages 20-21 of this guide for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

# Contact List

| BENEFIT | VENDOR | GROUP # | PHONE # | WEB |
|---|---|---|---|---|
| **Medical** | UnitedHealthcare | 909727 | Broad - 866.844.4864<br>Charter – 877.805.1970<br>Nexus – 888.331.3408 | www.myuhc.com |
| **Prescription Drugs** | UnitedHealthcare/ Optum | 909727 | Broad - 866.844.4864<br>Charter – 877.805.1970<br>Nexus – 888.331.3408 | www.myuhc.com |
| **Dental** | Aetna | 176629 | 877.238.6200 | www.aetna.com |
| **Vision** | MetLife | 05926411 | 800.438.6388 | www.metlife.com |
| **Flexible Spending Account** | WEX | 28985 | 866.451.3399 | https://benefitslogin.wexhealth.com |
| **Long Term Disability** | UnitedHealthcare | 306922 | 888.299.2070 | www.myuhc.com |
| **Short Term Disability** | UnitedHealthcare | 306922 | 888.299.2070 | www.myuhc.com |
| **Group Life / AD&D** | UnitedHealthcare | 306922 | 888.299.2070 | www.myuhc.com |
| **Voluntary Life / AD&D** | UnitedHealthcare | 306922 | 888.299.2070 | www.myuhc.com |
| **EAP** | Optum | access code: pasadena | 866.248.4094 | liveandworkwell.com |
| **Life Planning and Legal Services** | UnitedHealthcare/ Optum | 306922 | 877.660.3806 | liveandworkwell.com |
| **Member Assistance Program** | UnitedHealthcare | FP3EAP | 800.527.0218 | liveandworkwell.com |
| **Advocate Center** | Gallagher | N/A | 832.918.3761 | bac.cityofpasadena@ajg.com |

**For more information about the benefit offerings, please see our Benefits Resource Center page:**

**Just scan the QR Code for a link to the page.**

City of Pasadena is proud to provide our employees and their families with a comprehensive and affordable benefits package, allowing you to enroll in those plans that best fit your family's needs. This guide can help you make sure you're enrolled in the benefits that best fit your life situation. At this time, you may enroll or make changes to your elections. Get ready by taking the time to know more about your options and then take action to enroll.

- **Employee Eligibility:** All FT (full-time) employees are eligible for Medical, Dental/Vision, Life and Disability benefits first of the month following date of hire. **For example**, if an employee begins work on May 15, 2025, his or her benefits would be effective June 1, 2025.
- **Dependent Eligibility:** Dependents eligible for coverage include your legal spouse and children under age 26. For medical, children under age 26 are eligible regardless of marital or dependent status. For dental, unmarried children under the age of 26 only. Older children who were disabled prior to the limiting age and grandchildren are also considered eligible dependents if you are their legal guardian and are claiming them as a dependent for tax purposes.
- **Benefit Enrollment Period:** After your initial enrollment period (when you first become eligible for benefits), you may enroll, waive coverage, or change your benefit elections during the stated annual open enrollment period each year (for coverage to become effective January 1) or at any time during the plan year in the event of a qualified change in status (also called a "life event"). **If you have a change in status and wish to change any of your benefit elections, you must complete an election change form *within 30 days of the date of the event.***
- **Upon Your Initial Date of Eligibility** you will be enrolled in all lines of coverage which are 100% employer-paid (no cost to you). These lines of coverage include Group Term Life, Short-Term Disability, Long-Term Disability and the Employee Assistance Program.

## Qualified Changes in Status:

- Employee's marriage or divorce or death of employee's spouse
- Birth, adoption or death of a dependent child
- Change in employee's, spouse's or dependent child's employment status that affects benefit eligibility
- Child becoming ineligible for coverage due to reaching age 26
- Change in the employee's, spouse's or a dependent child's residence that affects eligibility for coverage
- Employee's receipt of a Qualified Medical Child Support Order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) Medical coverage for a child
- Changes made by a spouse or dependent child during his/her annual enrollment period with another employer
- The employee, spouse or dependent child becoming eligible or ineligible for CHIP, Medicare or Medicaid
- Significant employer – or carrier – initiated changes in or cancellation of the employee's, spouse's or dependent child's coverage

## Supporting Documents Required to Add Dependents

**Legal Spouse / Domestic Partner:**

- Social Security Card (copy)
- Marriage Certificate copy front and back/Declaration of Informal Marriage (Common Law)
- Your most recent joint tax return or two joint financial statements

**Dependent Child(ren) Biological, Adopted, or Legal Guardian:**

- Social Security Card (copy)
- Birth Certificate (copy)

**Stepchildren:**

- Social Security Card (copy)
- Birth Certificate (copy)
- Marriage Certificate (copy front and back)

**Adopted / Court Ordered Dependents:**

- Social Security Card (copy)
- Adoption / Guardianship Documents (copy)
- Custody / Court Order Documents (copy)

**** FAILURE TO TURN IN THESE DOCUMENTS MAY RESULT IN DEPENDENTS NOT HAVING COVERAGE.**

# Medical

**Administered through UnitedHealthcare**

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

| | Plan B | Plan C |
|---|---|---|
| | In-Network Only | In-Network Only |
| **Annual Deductible (ded)** | $1,500 Ind./$3,000 Fam. | $3,000 Ind./$6,000 Fam. |
| **Maximum Out-of-Pocket** | Broad Choice-$5,750 Ind./$12,500 Fam.<br>Charter Network-$5,000 Ind./$9,000 Fam.<br>Nexus Network-$5,000 Ind./$9,000 Fam. | Broad Choice-$5,750 Ind./$12,500 Fam.<br>Charter Network-$6,000 Ind./$12,500 Fam.<br>Nexus Network-$6,000 Inc./$12,500 Fam. |
| **Routine Preventive Care** | $0 copay | $0 copay |
| **Primary Care** | Broad Choice – $35 copay<br>Charter Network – $35 copay<br>Nexus Network – $35*/$70 copay | Broad Choice – $35 copay<br>Charter Network – $35 copay<br>Nexus Network – $35*/$70 copay |
| **Specialist** | Broad Choice – $35*/$50 copay<br>Charter Network – $50 copay<br>Nexus Network – $50*/$100 copay | Broad Choice – $35*/$50 copay<br>Charter Network – $50 copay<br>Nexus Network – $50*/$100 copay |
| **Virtual Visit** | $0 copay | $0 copay |
| **Lab and X-ray** | 20% after deductible | 20% after deductible |
| **Inpatient Hospital** | Broad Choice – 20% after deductible<br>Charter Network – 20% after deductible<br>Nexus Network – 20% after deductible*/<br>$500 copay + 40% after deductible | Broad Choice – 20% after deductible<br>Charter Network – 20% after deductible<br>Nexus Network – 20% after deductible*/<br>$500 copay + 40% after deductible |
| **Outpatient Hospital** | Broad Choice – 20% after deductible<br>Charter Network – 20% after deductible<br>Nexus Network – 20% after deductible*/<br>40% after deductible | Broad Choice – 20% after deductible<br>Charter Network – 20% after deductible<br>Nexus Network – 20% after deductible*/<br>40% after deductible |
| **Emergency Services** | 20% after deductible | $200 copay + 20% |
| **Urgent Care Services** | $75 copay | $75 copay |
| **Inpatient Mental Health** | 20% after deductible | 20% after deductible |
| **Outpatient Mental Health** | Broad Choice – $35 copay<br>Charter Network – $35 copay<br>Nexus Network – $50 copay | Broad Choice – $35 copay<br>Charter Network – $35 copay<br>Nexus Network – $50 copay |

| Rx BENEFIT | All Plans |
|---|---|
| **Pharmacy Deductible** | $100 Per person |
| **Tier 1** | $5 or 20% Retail / $25 Mail Order |
| **Tier 2** | $35 or 20% Retail / $65 Mail Order |
| **Tier 3** | $35 or 20% Retail / $65 Mail Order |

*Designated Network copays

You can receive a 90-day supply of medicine through Optum Rx pharmacy benefit. Visit www.myuhc.com or call the number on the back of your card to set up your mail order service.

## Medical Contributions

The group health premiums listed include the discounted rate of $50 monthly for employee-only or employee-child(ren) and $100 monthly for employee-spouse coverage for completing the Annual Personal Health Assessment (PHA). To continue the discounted rate employees, newly hired employees and spouses/domestic partners covered on the City's group health insurance must complete the PHA or submit a PHA affidavit by **December 26, 2025**.

Medical Contributions will be divided between 2 paychecks each month.

| Plan B | | | |
|---|---|---|---|
| | **Broad Choice UHC** | **Nexus Memorial Hermann** | **Charter Kelsey Seybold** |
| **Employee Only** | $80.00 | $55.00 | $55.00 |
| **Employee + Spouse** | $235.00 | $192.50 | $192.50 |
| **Employee + Children** | $174.00 | $143.00 | $143.00 |
| **Employee + Family** | $328.00 | $269.50 | $269.50 |
| **Plan C** | | | |
| **Employee Only** | $30.00 | $15.00 | $15.00 |
| **Employee + Spouse** | $105.00 | $53.00 | $53.00 |
| **Employee + Children** | $78.00 | $39.00 | $39.00 |
| **Employee + Family** | $147.00 | $74.00 | $74.00 |

## Which Network Is Best for me?

| | Choice Plans B, C<br>Broad Network | Nexus Plans B, C<br>Memorial Hermann Network | Charter Plans B, C<br>Kelsey Seybold Network |
|---|---|---|---|
| **Question?** | **Answer** | **Answer** | **Answer** |
| **Is this an Exclusive Provider Organization (EPO) or Accountable Care Organization (ACO), and what does it really mean?** | These plans are EPO Plans and use the Broad network called Choice. You can go to any provider in the network without the need of a referral. | This is an ACO Plan that uses a smaller network. The Nexus plans uses Memorial Hermann and UT Physicians - a preferred network of quality providers who work together to coordinate your care | This is an ACO Plan that uses a smaller network. The Charter Plans use Kelsey Seybold providers and facilities in and around the Houston area without needing a referral if you stay within the Kelsey Network. |
| **Do I need to select a Primary Care Physician (PCP)?** | Broad Network plans do not require you select a PCP. You are free to receive treatment from any Choice Network provider found on myuhc.com. | Yes, you will need to select a PCP. However, you are free to see any physician (primary care or specialty care) in the Nexus Open Access Network without a referral. | No. You are encouraged to select a Kelsey PCP to coordinate your care but you are not required to select one. |
| **Do I need a referral to see a specialist?** | No. These plans are tied to the Broad network called Choice. You can choose to go to any provider in the network without the need of a referral. | No, you do not need a referral to see a specialist. Please be sure to use a Memorial Hermann or UT Physician specialist. | No, you do not need a referral to see a specialist as long as you stay within the Kelsey Seybold network of physicians. Mental Health and Substance Abuse services are not provided by Kelsey Seybold. You will need to seek services from Mental Health providers on myuhc.com. A referral is not needed |
| **How do I know if my provider is part of this network?** | www.welcometouhc.com/choice | www.welcometouhc.com/nexus2 | https://www.kelsey-seybold.com/find-a-houston-doctor |
| **Who's responsibility is it to know if my provider is in network?** | It is the member's responsibility to confirm the provider, from whom you are seeking treatment, is in the network you select. | It is the member's responsibility to confirm the provider, from whom you are seeking treatment, is in the network you select. | It is the member's responsibility to confirm the provider, from whom you are seeking treatment, is in the network you select. |
| **How do I locate a Tier 1 Doctor?** | Once enrolled, please register on myuhc.com and download the Health4Me app to your phone. This will provide you with quick access to your network providers at anytime including Tier 1 providers. | Once enrolled, please register on myuhc.com and download the Health4Me app to your phone. This will provide you with quick access to your network providers at anytime including Tier 1 providers. | The Charter network does not have a Tier 1 physician designation. |
| **What do I do if my provider is not part of the network?** | If your provider is not in the network, you will need to change providers in order to benefit from your medical insurance. If you choose to receive treatment from an out-of-network provider, you will pay 100% of the cost. | If your provider is not in the network, you will need to change providers in order to benefit from your medical insurance. If you choose to receive treatment from an out-of-network provider, you will pay 100% of the cost. | If your provider is not in the network, you will need to change providers in order to benefit from your medical insurance. If you choose to receive treatment from an out-of-network provider, you will pay 100% of the cost. |
| **What if I have a college student living outside of the service area?** | Your network is a national network. You may seek services from any Choice network provider. Simply use myuhc.com or the Health4Me app to locate the closest network provider to you. Remember your plan also covers Virtual Visits at a $0 copay. | Your network is a national network. You may seek services from any Choice network provider. Simply use myuhc.com or the Health4Me app to locate the closest network provider to you. Remember your plan also covers Virtual Visits at a $0 copay. | Your college student has access to Virtual Visits at a $0 copay and Urgent Care services. |
| **Are all major hospital systems included in my network?** | Yes, major hospitals are included in the Broad (Choice) network. Please use myuhc.com for contracted hospitals in your area. | Yes, major hospitals are included in the Nexus network. However, in order to keep your out of pocket cost low, please seek services from a Memorial Hermann facility. (Lowest Copays) | Major hospitals are included in the network with the exception of MD Anderson. The Kelsey Seybold Cancer Center is a nationally recognized cancer center with a QOPI certification. Should you have a rare form of cancer that cannot be treated at Kelsey, you may be referred to MD Anderson. |
| **What if I am in a true emergency, can I go to any hospital?** | In the event of a true emergency, your claim will be processed at the In-Network level, regardless if the Emergency Room is contracted or not. | In the event of a true emergency, your claim will be processed at the In-Network level, regardless if the Emergency Room is contracted or not. | In the event of a true emergency, your claim will be processed at the In-Network level, regardless if the Emergency Room is contracted or not. |
| **Will my copays differ depending on the type of provider I see?** | Yes. When searching for a provider, if you seek services from a Tier 1 provider, you may pay lower copays. If you receive treatment from a provider without the Tier 1 designation, you will pay a higher copay. | Yes. When searching for a provider, if you seek services from a Memorial Hermann or UT physician provider, you will pay a lower copay. If you receive treatment from any other In-Network provider, you will pay a higher copay. | No, your PCP copay and Specialist copay will always stay the same. |

# Compare options, help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to $2,500 compared to an emergency room (ER) visit.*

| Care options to consider | START HERE<br>**Primary care provider (PCP)**<br>The provider who may know you best | **24/7 Virtual Visits**<br>A care provider over the phone or by video | **Convenience care**<br>Nurse practitioners and physician assistants at retail pharmacy clinics | **Urgent care**<br>Physicians and care teams at walk-in clinics | **Emergency room**<br>Physicians and care teams at hospital emergency departments |
|---|---|---|---|---|---|
| **Average cost*** | **In-person: $175<br>Virtual: $99 or less**** | **$54***** | **$100** | **$185** | **$2,700** |
| Allergies | ✓ | ✓ | | | |
| Bladder infection/UTI | ✓ | | | ✓ | |
| Broken bone | | | | ✓ | ✓ |
| Bronchitis | ✓ | ✓ | | ✓ | |
| Chest pain | | | | | ✓ |
| Cough | ✓ | ✓ | ✓ | | |
| COVID-19 symptoms | ✓ | | | ✓ | |
| Earache | ✓ | ✓ | ✓ | | |
| Fever | ✓ | ✓ | | | |
| Flu/common cold | ✓ | ✓ | ✓ | | |
| Migraine/headache | ✓ | ✓ | | | |
| Muscle ache/sprain | ✓ | | | ✓ | |
| Pinkeye | ✓ | ✓ | | | |
| Shortness of breath | | | | | ✓ |
| Sinus infection | ✓ | ✓ | | | |
| Skin rash | ✓ | ✓ | ✓ | | |
| Sore throat | ✓ | ✓ | | | |
| Stomach pain (nausea, vomiting, diarrhea) | ✓ | | | ✓ | |
| Yeast infection | ✓ | ✓ | | | |

✓ **Indicates the care option to consider for the common conditions listed**

**Learn more** Visit **uhc.com/quickcare**

United Healthcare®

# It pays to be in-network

## Helping make it easier to find quality physicians

We recognize physicians who meet safe, timely, effective and efficient quality care criteria. You can find these physicians when using the UnitedHealthcare® app, visiting myuhc.com or speaking with an advocate when calling the number on your ID card.

**Better coverage**
Your UnitedHealthcare medical plan offers access to a large, national network that includes more than 1.78 million health care providers and 5,500 hospitals.

**Lower costs**
Negotiated rates with network providers may help you spend less.

**Less paper work**
Network providers secure approvals for services and submit your claims to UnitedHealthcare for you.

continued

## In this example, you may owe up to $6,640 if you seek care at an out-of-network provider*

The following example shows how your financial responsibility may be lower when you seek care from a network provider rather than an out-of-network (OON) provider.

**ACL knee repair at outpatient ambulatory surgery center**

| | Network | Out-of-network |
|---|---|---|
| A. Provider billed | $10,000 | $10,000 |
| B. Network discount | $6,500 | Not applicable |
| C. Amount allowed** | $3,500 | $4,200 |
| D. Health plan paid | $2,800 | $3,360 |
| E. Your responsibility***, † | $700 | $840 |
| F. Potential balance bill from the provider to you ‡ | Not applicable | $5,800 |
| **Potential member responsibility (E+F)** | **$700** | **$6,640** |

**Difference of $5,940**

### To find providers and facilites within your network:

Call the number on your ID card, download the UnitedHealthcare® app or visit **myuhc.com.**

### To seek help with resolving out-of-network balance medical bills:

If you do owe for out-of-network medical services, reach out to us. Your plan may come with Naviguard®, a UnitedHealthcare service, offering simple and efficient balance bill resolution options at no additional cost to you. Naviguard may be available to help review your bill and negotiate a reduced amount on your behalf. **Visit naviguard.com/uhc-member** or call UnitedHealthcare Member Services at 1-833-593-4154.

Providers and hospitals, Q1 2024 data.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

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

The UnitedHealthcare® app is available for download for iPhone® or AndroidTM. iPhone is a registered trademark of Apple, Inc. Android is a trademark of Google LLC.*

Example is for illustrative purposes only and assumes that the annual deductible has been met. Billed and allowed amounts vary by provider. Out-of-network providers set their own rates and may bill you for the difference between their rates and what UnitedHealthcare pays.

** The amount contracted between network providers and UnitedHealthcare for this service. The $4,200 in row C is the allowed amount for an out-of-network provider. This is an illustrative claim example and does not represent your actual claim situation.

*** This example assumes that the deductible has been met.

† Network coinsurance is 20% of row C.

‡ Difference between rows A and C for out-of-network.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Health Plan coverage provided by or through a UnitedHealthcare company.



United Healthcare®

# Dental

**Insured by Aetna**

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the City of Pasadena's dental benefit plans.

| BENEFIT | PPO | DMO |
|---|---|---|
| **Calendar Year Deductible** | $50 per person / $150 per family | Unlimited |
| **Preventive Care** (Cleanings, Exams, X-ray) | 100% Covered | Various copays |
| **Basic Care** (Endo, Perio, Oral Surgery) | 20% after deductible | Various copays |
| **Major Care** (Crowns, Bridges, Dentures) | 50% after deductible | Various copays |
| **Orthodontics** (Adults & Children) | N/A | Various copays |
| **Annual Benefit Maximum** | $1,500 per person | Unlimited |

# Vision

**Insured by MetLife**

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK REIMBURSEMENT |
|---|---|---|
| **Exams and Materials** | $10 copay / $10 copay | Up to $45 |
| **Frame**[1] | $150 retail allowance + 20% off remaining balance | Up to $70 |
| **Standard Lenses**[2] | Single Lenses: Covered in full<br>Bifocal: Covered in full<br>Trifocal: Covered in full<br>Additional lens enhancements: 20-25% discount | Single: Up to $30<br>Bifocal: Up to $50<br>Trifocal: Up to $65 |
| **Contact Lenses** | Elective: $150 Allowance<br>Necessary: Covered in full<br>Lens fitting and evaluation: Up to $60 copay | Elective: Up to $105<br>Necessary: Up to $210 |
| **Frequency** | Exam: 1 every 12 months<br>Contacts or Frames and Lenses: 1 every 12 months | |
| **Laser Vision Correction** | 15-20% off retail price or 5% off promotional price | N/A |

[1]Costco, Walmart and Sam's Club: **$85** allowance after **$10** eyewear copay. Additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.

[2]Standard lens enhancements, 20-25% savings on all other lens enhancements.

## Dental and Vision Contributions

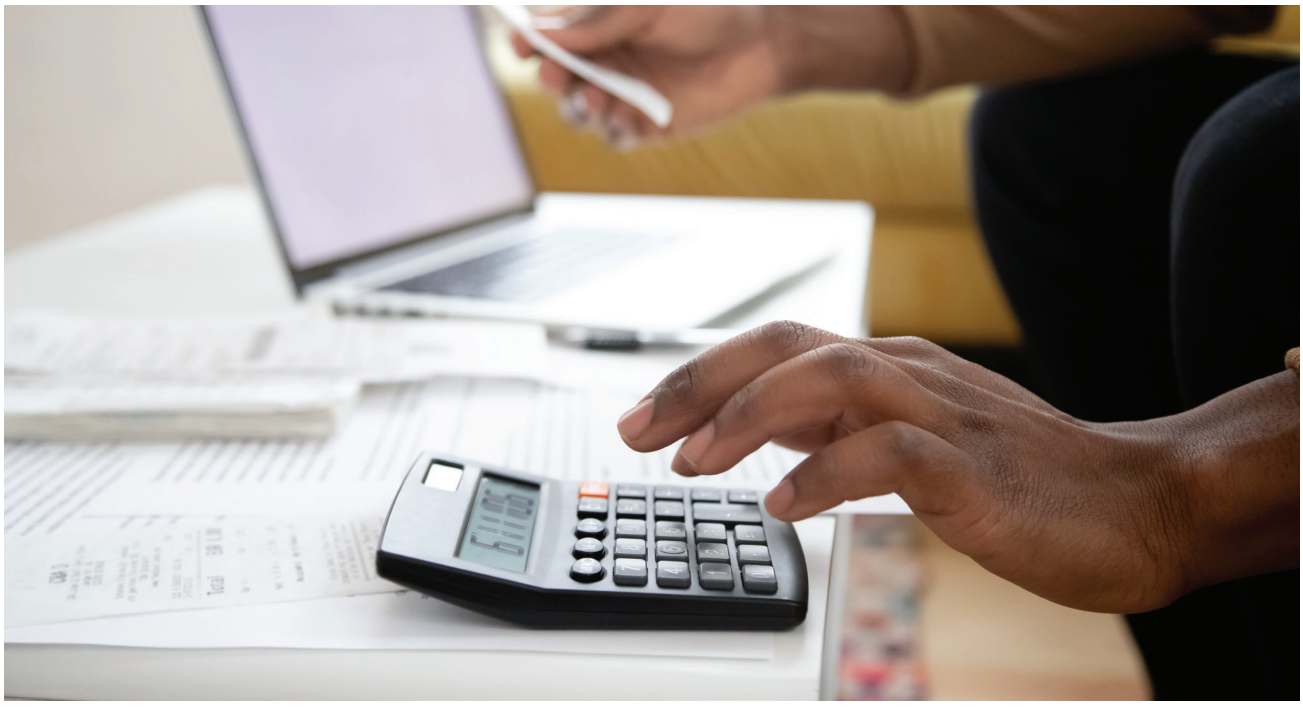
Dental and Vision contributions will be deducted from your paycheck once a month.

| | Aetna DPPO | Aetna DMO | MetLife Vision |
|---|---|---|---|
| **Employee Only** | $9.32 | $0.23 | $8.33 |
| **Employee + Spouse** | $40.75 | $8.03 | $16.68 |
| **Employee + Children** | $40.43 | $8.90 | $17.17 |
| **Employee + Family** | $66.92 | $18.43 | $23.77 |

# Flexible Spending Accounts

**Administered through WEX (Discovery Benefits)**

| PLAN | HEALTH CARE FSA* | DEPENDENT CARE FSA |
|---|---|---|
| **Tax-free earnings pay for:** | Medical, dental and vision expenses for you and your dependents | Day care expenses for your eligible dependents |
| **Important Information:** | Eligible expenses include:<br>■ Deductibles, copays, coinsurance<br>■ Prescription drugs, allergy shots, insulin and syringes, physicals<br>■ Chiropractor treatments, psychiatric and psychologist fees<br>■ Smoking cessation programs, weight loss programs for disease<br>■ Wheelchair/crutches or other durable medical equipment<br>■ Non-cosmetic dental care including exams, x-rays, fillings, root canals<br>■ Eye exams, prescription eyeglasses and prescription sunglasses<br>■ Corrective eye surgery (LASIK, cataract, corneal rings, etc)<br>■ Contact lenses, cleaning solutions<br>■ Hearing exams, aids & batteries<br>■ And more | Eligible dependent care expenses for:<br>■ Dependent children under age 13<br>■ A disabled spouse who is mentally or physically incapable of self care<br>■ Your dependent who is physically or mentally not able to care for himself or herself and for whom you can claim an exemption (or could claim an exemption except the person had $3,000 or more of gross income)<br>■ NOTE: Expenses must be incurred during the period of coverage. Please see IRS Publications 502 and 503 details of Medical and Dependent Care Reimbursement rules |
| **Annual Contribution Maximums** | $3,200 maximum | $2,500 max if tax-filing single $5,000 max if married and filing jointly or a single parent |
| **“Use it or Lose it”** | Any amount not spent will be forfeited after **March 15th** of the following year. | Any amount not spent will be forfeited at year end (**December 31**) |
| **Tax Information** | Contributions are made on a pre-tax basis, expenses claimed under your health care or dependent care FSA may not be claimed as a tax credit on your federal tax return. | |



# Disability

**Insured by and Administered through UnitedHealthcare**

City of Pasadena provides employer-paid Disability benefits, which all full-time employees working 40 hours a week receive at no cost. For additional details, ask HR for a copy of the plan documents.

## Short Term Disability

- Weekly benefit of up to 60% of weekly earnings
- Coverage begins on 31st day off the job
- Coverage lasts up to 48 weeks
- Maternity Coverage is Included

## Long Term Disability

- Monthly benefit of up to 60% of monthly earnings
- $6,000 maximum monthly benefit
- Coverage begins on 361st day off the job
- Coverage lasts until age 65 (see COC for more info)
- First 24 Months look at Own Occupation

# Optum MAP/EAP

Our Member Assistance Program from Optum® offers you and your family up to 3 referrals for face-to-face counseling, personal and confidential support available 24 hours a day, 7 days a week to those electing the LTD benefit.

For all city employees, the Employee Assistance Program includes 6 face-to-face counseling sessions, Legal and financial consultation, Referrals to community resources

## Live and Work Well

**Legal**: Create a will, living will, health care directive or a durable/financial power of attorney, Estate Planning

**Financial**: Financial planning to help your beneficiaries, Option to open Bank Account at Optum Bank to assist with money management

**Emotional**: Grief Support with unlimited phone and up to 6 face-to-face meetings for all City employees

**Physical**: assistance with Social Security Office, Credit Card Companies, Government agencies, social media shut down, and Fraud Resolution to protect identities.

## Travel Assistance Program

Access to 24/7 support by phone or online when traveling for business or pleasure. Help with medical emergencies or other travel-related issues, like a stolen passport, and more.

# Group Term Life / AD&D

**Insured by UnitedHealthcare**

Life insurance can provide security for your dependents in the event of your death or terminal illness. The City of Pasadena provides a basic level of life insurance for all full-time employees of $25,000.

## Optional Term Life and AD&D

Employees can purchase additional life and AD&D insurance coverage through UHC for themselves and their families.

### EMPLOYEE COVERAGE

- 5x your annual salary, up to $500,000 whichever is less
- Increments of $10,000
- Guaranteed issue limit: $200,000

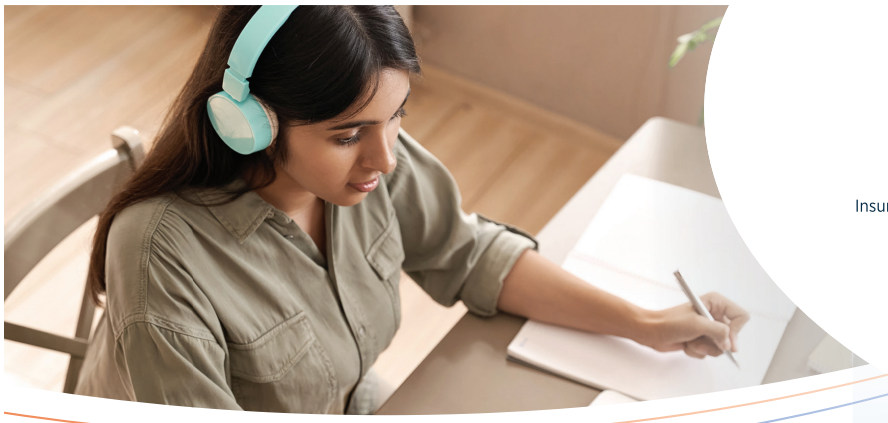
### DEPENDENT COVERAGE

- Dependent coverage no more than EE Coverage
- Spouse coverage in units of $5,000, up to $25,000
- Spouse Guaranteed issue limit: $25,000
- Child coverage in units of $2,000 up to $10,000
- Child Guaranteed issue limit: $10,000 after 6 months of age, Live Birth to 6 months: $1,000

*Existing amounts will be grandfathered without Evidence of Insurability (EOI). If you are applying for new supplemental coverage more than 31 days after you first became eligible or requesting an amount over the Guaranteed Issue amount, you must submit an Evidence of Insurability (EOI) form.*

***Benefit coverage reduces for employee and spouse beginning at employees' attainment of age 65.***

| **Employee: The rates shown below are per $10,000 of coverage for employee.** | | | | | |
|---|---|---|---|---|---|
| **Your Age** | **Cost Per Month** | **Your Age** | **Cost Per Month** | **Your Age** | **Cost Per Month** |
| **Under Age 24** | $0.50 | Age 40-44 | $1.45 | Age 60-64 | $8.90 |
| **Age 25-29** | $0.70 | Age 45-49 | $1.95 | Age 65-69 | $15.20 |
| **Age 30-34** | $0.70 | Age 50-54 | $3.56 | Age 70-74 | $29.50 |
| **Age 35-39** | $1.05 | Age 55-59 | $5.98 | Age 75+ | $59.60 |
| **Spouse: The rates shown below are per $5,000 of coverage for spouse and are based on employee age.** | | | | | |
| **Your Age** | **Cost Per Month** | **Your Age** | **Cost Per Month** | **Your Age** | **Cost Per Month** |
| **Under Age 24** | $0.25 | Age 40-44 | $0.73 | Age 60-64 | $4.45 |
| **Age 25-29** | $0.35 | Age 45-49 | $0.98 | Age 65-69 | $7.60 |
| **Age 30-34** | $0.35 | Age 50-54 | $1.78 | Age 70-74 | $14.75 |
| **Age 35-39** | $0.53 | Age 55-59 | $2.99 | Age 75+ | $29.80 |
| **Child: Child rate is $0.50 for $2,000 of coverage.** | | | | | |



Gallagher

Insurance | Risk Management | Consulting

# Ask Your Advocate Team

## Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:

1. **Explanation of benefits**
   Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
2. **Prescription challenges**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?
3. **Benefits questions**
   Are you unsure if the insurance company will pay for a certain procedure?
4. **Claim issues**
   Did you receive a bill from a doctor but don't know why?
5. **Difficult situations**
   Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

**A licensed healthcare benefits advocate is ready to handle any situation in a discreet and confidential manner.**

## Hours of operation

Monday – Friday
8 a.m. – 6 p.m.

## Connect With Us

**City of Pasadena**

832.918.3761
bac.cityofpasadena@ajg.com

ajg.com **The Gallagher Way.** Since 1927.

# Legal Notices

## Women's Health & Cancer Rights Act Notices

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, contact Human Resources.

## Michelle's Law Notice

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under The City of Pasadena's Group Health Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under The City of Pasadena's Group Health Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under The City of Pasadena's Group Health Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's law, please contact **Human Resources**.

## HIPAA Notices

### THE CITY OF PASADENA'S INITIAL NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Our records show that you are eligible to participate in The City of Pasadena's Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

**Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

**Loss of Coverage for Medicaid or a State Children's Health Insurance Program**. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

E**ligibility for Medicaid or a State Children's Health Insurance Program.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact **Human Resources**.

## Protecting Your Health Information Privacy Rights

The City of Pasadena is committed to the privacy of your health information. The administrators of the City of Pasadena's Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting **Human Resources.**

## Your Rights and Protections Against Surprise Medical Bills

**When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.**

### WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

**You are protected from balance billing for:**

### EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

### CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

### WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Human Resources.

## IMPORTANT NOTICE FROM THE CITY OF PASADENA'S 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 Pasadena's Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not 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 Pasadena's Health Plan has determined that the prescription drug coverage offered by the City of Pasadena's 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 The City of Pasadena's Health Plan coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current The City of Pasadena's Health Plan 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 of Pasadena's Health Plan 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 below for further information Human Resources. 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 Pasadena's Health Plan 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).

**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).**

| | |
|---|---|
| **Date:** | January 1, 2025 |
| **Name of Entity/Sender:** | City of Pasadena |
| **Contact:** | Human Resources |
| **Address:** | 1149 Ellsworth Drive<br>Pasadena, TX 77506 |

## 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 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 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 January 31, 2024. Contact your state for more information on eligibility.**

| **ALABAMA – Medicaid** |
|---|
| http://myalhipp.com<br>855.692.5447 |
| **ALASKA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>http://myakhipp.com/ \| 866.251.4861<br>CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** |
| http://myarhipp.com<br>855.MyARHIPP (855.692.7447) |
| **CALIFORNIA – Medicaid** |
| Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>916.445.8322 \| Fax: 916.440.5676\| Email: hipp@dhcs.ca.gov |
| **COLORADO – Medicaid and CHIP** |
| Health First Colorado (Colorado's Medicaid Program)<br>https://www.healthfirstcolorado.com<br>Member Contact Center: 800.221.3943 \| State Relay 711<br>Child Health Plan Plus (CHP+)<br>https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>Customer Service: 800.359.1991 \| State Relay 711<br>Health Insurance Buy-In Program (HIBI)<br>https://www.mycohibi.com/<br>HIBI Customer Service: 855.692.6442 |
| **FLORIDA – Medicaid** |
| www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>877.357.3268 |

| **GEORGIA – Medicaid** |
|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>678.564.1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>678.564.1162, Press 2 |
| **INDIANA – Medicaid** |
| Healthy Indiana Plan for low-income adults 19-64<br>http://www.in.gov/fssa/hip/ \| 877.438.4479<br>All other Medicaid<br>https://www.in.gov/medicaid/ \| 800.457.4584 |
| **IOWA – Medicaid and CHIP (Hawki)** |
| Medicaid: https://dhs.iowa.gov/ime/members \| 800.338.8366<br>Hawki: http://dhs.iowa.gov/Hawki \| 800.257.8563<br>HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp \| 888.346.9562 |
| **KANSAS – Medicaid** |
| https://www.kancare.ks.gov/<br>800.792.4884 \| HIPP Phone: 800.967.4660 |
| **KENTUCKY – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>855.459.6328 \| KIHIPP.PROGRAM@ky.gov<br>KCHIP: https://kynect.ky.gov \| 877.524.4718<br>Medicaid: https://chfs.ky.gov/agencies/dms |
| **LOUISIANA – Medicaid** |
| www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP) |

| MAINE – Medicaid |
| --- |
| Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>800.442.6003 \| TTY: Maine relay 711<br>Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms<br>800.977.6740 \| TTY: Maine relay 711 |
| **MASSACHUSETTS – Medicaid and CHIP** |
| https://www.mass.gov/masshealth/pa<br>800.862.4840 \| TTY: 711\| Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** |
| https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>800.657.3739 |
| **MISSOURI – Medicaid** |
| http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>573.751.2005 |
| **MONTANA – Medicaid** |
| http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>800.694.3084 \| Email: HHSHIPPProgram@mt.gov |
| **NEBRASKA – Medicaid** |
| http://www.ACCESSNebraska.ne.gov<br>Phone: 855.632.7633 \| Lincoln: 402.473.7000 \| Omaha: 402.595.1178 |
| **NEVADA – Medicaid** |
| http://dhcfp.nv.gov<br>800.992.0900 |
| **NEW HAMPSHIRE – Medicaid** |
| https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>603.271.5218 \| Toll free number for the HIPP program: 800.852.3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** |
| Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid<br>609.631.2392<br>CHIP: http://www.njfamilycare.org/index.html<br>800.701.0710 |
| **NEW YORK – Medicaid** |
| https://www.health.ny.gov/health_care/medicaid/<br>800.541.2831 |
| **NORTH CAROLINA – Medicaid** |
| https://dma.ncdhhs.gov<br>919.855.4100 |
| **NORTH DAKOTA – Medicaid** |
| https://www.hhs.nd.gov/healthcare<br>844.854.4825 |
| **OKLAHOMA – Medicaid and CHIP** |
| http://www.insureoklahoma.org<br>888.365.3742 |

| OREGON – Medicaid and CHIP |
| --- |
| http://healthcare.oregon.gov/Pages/index.aspx<br>800.699.9075 |
| **PENNSYLVANIA – Medicaid and CHIP** |
| https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>800.692.7462<br>CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx<br>CHIP Phone: 800.986.KIDS (5437) |
| **RHODE ISLAND – Medicaid and CHIP** |
| http://www.eohhs.ri.gov<br>855.697.4347 or 401.462.0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** |
| http://www.scdhhs.gov<br>888.549.0820 |
| **SOUTH DAKOTA – Medicaid** |
| http://dss.sd.gov<br>888.828.0059 |
| **TEXAS – Medicaid** |
| https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program<br>800.440.0493 |
| **UTAH – Medicaid and CHIP** |
| Medicaid: https://medicaid.utah.gov<br>CHIP: http://health.utah.gov/chip<br>877.543.7669 |
| **VERMONT – Medicaid** |
| Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>800.250.8427 |
| **VIRGINIA – Medicaid and CHIP** |
| https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid and Chip: 800.432.5924 |
| **WASHINGTON – Medicaid** |
| https://www.hca.wa.gov/<br>800.562.3022 |
| **WEST VIRGINIA – Medicaid and CHIP** |
| https://dhhr.wv.gov/bms/ or http://mywvhipp.com/<br>Medicaid: 304.558.1700<br>CHIP Toll-free: 855.MyWVHIPP (855.699.8447) |
| **WISCONSIN – Medicaid and CHIP** |
| https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>800.362.3002 |
| **WYOMING – Medicaid** |
| https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>800.251.1269 |

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

**U.S. Department of Labor**
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

*This benefits guide prepared by*

Gallagher

Insurance | Risk Management | Consulting