2019 Pre-65 Benefits Guide

The City of San Angelo

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IMPORTANT: IF YOU OR YOUR DEPENDENTS HAVE MEDICARE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS, THE MEDICARE PRESCRIPTION DRUG PROGRAM GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. PLEASE SEE PAGE 18-19 FOR MORE DETAILS.

Benefits Overview

Our Benefits Program Has You Covered

Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. But sometimes things don't always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he needs an extensive root canal. That's when the City's benefits are there to help you.

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. The City's plans allow you to choose the plans that work best for your own needs—and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

What's new in the 2019 plan year?

Please refer to the appropriate benefit page for plan information. This guide is intended to be a broad overview of your benefits. If you have additional questions regarding enrollment, benefits or product offerings, please contact Human Resources. This guide also includes phone numbers and websites for all your benefits carriers.

2018-2019 HealthCare Reform Changes

Individual Mandate

Health Care Reform used to require that individuals maintain "minimum essential coverage." This penalty is being removed for 2019. Depending on your healthcare needs and what you can afford, you can choose minimum essential coverage plan or enroll in alternative coverage (e.g., short-term health insurance, a hospital plan) instead and not owe a tax penalty. Those with pre-existing conditions may not be eligible for these alternative plans and may want to consider a major medical insurance policy instead. It is important to know that these alternative coverages do not offer the same benefits as major medical.

Important Contacts

Resource	Phone/Web Address
Aetna – Health and Prescription Drug Benefit	City of San Angelo Dedicated Helpline: 855-569-5723 www.Aetna.com
Delta Dental – DPO Benefits	Toll Free: 800-521-2651 Website: www.deltadentalins.com Claims mailing address: Delta Dental Insurance Company P.O. Box 1809 Alpharetta, GA 30023-1809
Superior Vision – Vision Benefits	866-265-0517 (for members, elect option 1) www.Superiorvision.com
City of San Angelo Benefits Representative	325-657-9265 Dolores Smith dolores.smith@cosatx.us

Pre-65 Retiree Medical Costs – Aetna Community Choice Health Plan

Tier 1: If you were hired prior to January 1, 2000:

- You are in Tier 1 if you retired **prior** to January 1, 2010 (regardless of number of years of service)
- You are in Tier 1 if you retired **after** January 1, 2010 with 20 or more years of service with COSA

Tier	Low Plan	Medium Plan	High Plan
Retiree Only (Under 65)	$20.44	$140.02	$223.48
Retiree (Under 65) + Spouse (Under 65)	$418.36	$677.20	$843.30
Retiree (Under 65) + Spouse (Over 65)	$325.44	$445.02	$528.48
Retiree (Under 65) + Child(ren)	$277.74	$481.88	$617.92
Retiree (Under 65) + Family	$578.26	$872.54	$1,068.70

Tier 2: If you were hired prior to January 1, 2000:

- You are in Tier 2 if you retired **after** January 1, 2010 with 15 years up to 19 years, 11 months service with COSA

Tier	Low Plan	Medium Plan	High Plan
Retiree Only (Under 65)	$152.70	$272.28	$355.74
Retiree (Under 65) + Spouse (Under 65)	$550.62	$809.46	$975.56
Retiree (Under 65) + Spouse (Over 65)	$457.70	$577.28	$660.74
Retiree (Under 65) + Child(ren)	$410.00	$614.14	$750.18
Retiree (Under 65) + Family	$710.52	$1,004.80	$1,200.96

Tier 3: If you were hired prior to January 1, 2000:

- You are in Tier 3 if you retired **after** January 1, 2010 with 5 years up to 14 years, 11 months service with COSA

If you were hired after January 1, 2000:

- You are in Tier 3 if you **retire** from COSA

Tier	Low Plan	Medium Plan	High Plan
Retiree Only (Under 65)	$549.47	$669.05	$752.51
Retiree (Under 65) + Spouse (Under 65)	$947.39	$1,206.23	$1,372.33
Retiree (Under 65) + Spouse (Over 65)	$854.47	$974.05	$1,057.51
Retiree (Under 65) + Child(ren)	$806.77	$1,010.91	$1,146.95
Retiree (Under 65) + Family	$1,107.29	$1,401.57	$1,597.73

Delta Dental

Tier	Low Plan	High Plan
Retiree Only	$18.40	$20.05
Retiree + Spouse	$45.28	$49.13
Retiree + Child(ren)	$57.14	$61.96
Retiree + Family	$84.02	$91.05

Superior Vision

Tier	Low Plan	High Plan
Retiree Only	$5.15	$6.03
Retiree + Spouse	$9.05	$10.30
Retiree + Child(ren)	$9.57	$10.92
Retiree + Family	$14.40	$16.33

Who Is Eligible

You are eligible to enroll in the City's benefit plans if you are a retiree of the City of San Angelo.

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26
- "Children" are defined as your natural children, stepchildren, legally-adopted children and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

> If your child becomes ineligible for coverage (i.e., turning age 26 under the health plan), you must notify your Benefits Representative at 325-657-9265.

Initial Enrollment

When you first retire from the City, you have 31 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first of the month following your date of retirement. If you do not enroll within 31 days of becoming eligible, you will not be able to enroll at a later date.

IMPORTANT: If you elect the City of San Angelo plan after you retire, and subsequently stop your retiree coverage under this plan, you will not be eligible to re-enroll later.

Annual Enrollment

During annual Open Enrollment, coverage takes effect on January 1 of the following year.

Helpful Definitions

- Calendar Year – January 1 through December 31 of each year.
- Coinsurance – The percent of eligible charges that the plan pays.
- Copayments (Copay) – The amount paid by a covered person to a network provider at the time services are rendered. Copayments for covered services are applied to your deductible.
- Deductible – The amount you pay each calendar year before the plan begins to pay covered health care expenses.
- Medical Emergency – A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.
- Network Benefits – The benefits applicable for the covered services of a network provider.
- Non-Network Benefits – The benefits applicable for the covered services of a non-network provider.
- Out-of-Pocket Maximum – The most a covered person will pay in deductibles and coinsurance in a calendar year for covered health care expenses (excluding reductions for provider contracts and usual and customary guidelines and copays).

Making Changes to Coverage

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualifying status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualifying status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by completing a Benefit Changes/Enrollment form and returning it to Human Resources. If you do not return your form within 31 days, you will need to wait until the next Open Enrollment to make new elections.

Qualifying status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes for you and your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualifying status changes, refer to the Summary Plan Description.

Special Enrollment Rules

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualifying events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described above, you may enroll yourself and your spouse (with or without the new dependent) in the City health plan following marriage or the adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call the Benefits Representative at (325) 657-9265.

Health Plan

The City's health options all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

Choosing a Health Option

When it comes to health coverage, the City offers you these choices through Aetna:

- Low Plan
- Medium Plan
- High Plan

Exclusive Provider Option (EPO)

The EPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an Aetna Community Choice in-network doctor or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because Aetna network providers discount their fees. And, with in-network providers, you generally do not have to file claims. If you choose to receive care from an out-of-network provider, the health plan pays a lower benefit and you may have to file a claim to receive reimbursement for covered expenses.

San Angelo Community Medical Center Partnership

San Angelo Community Medical Center (SACMC) welcomes the opportunity to serve as the in-network provider for the Community Choice health plan for the City of San Angelo. The hospital is a full-service, 171-bed acute care hospital and a designated Level III Trauma Center. They are the Concho Valley's only accredited Chest Pain Center and the only area hospital to receive Heart Failure accreditation. These accreditations complement the comprehensive heart and vascular care, including heart surgery and electrophysiology. SACMC is the leader in the City for robotic-assisted surgery. Experienced physicians offer robotic-assisted procedures in general surgery, gynecology, orthopedics and urology.

Other key services include a level II Neonatal Intensive Care Unit, women's and children's services, bariatric program, and a progressive orthopedic Joint Center for total and partial hip and knee surgeries.

More than 150 physicians have medical staff privileges at SACMC. They include members of physician groups such as Community Medical Associates and West Texas Medical Associates. These groups offer most specialties needed. In addition, a variety of independent practices, such as dermatology, offer depth to the medical staff. For minor emergencies, they offer two walk-in/urgent care clinic choices: Community ExpressCare – Sherwood Way and Community ExpressCare – Bryant, open 7am – 8pm seven days a week.

The hospital also offers a full service health club and wellness program, and is the exclusive health sponsor of the Laura W. Bush Institute for Women's Health in San Angelo.

Imaging Services

Cost sharing for Imaging Services will be based on the type of service performed and the location where services are rendered. For example, imaging in the office will pay differently than imaging in an outpatient facility.

Health Benefits

Plan Benefits	Aetna Low Plan In-network	Aetna Medium Plan In-network	Aetna High Plan In-network	Aetna Out-of-network
Annual Deductible	Deductibles apply toward out of pocket maximum			
Individual	$2,250	$1,500	$1,000	$4,000
Family	$5,600	$3,000	$2,000	$10,000
Out of Pocket Max (Includes Deductible)				
Individual	$6,600	$3,500	$2,000	$10,000
Family	$13,200	$9,350	$4,500	$30,000
Coinsurance	80%	80%	80%	50%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Services				
Immunizations (birth to 6th years)	100%	100%	100%	50%
Routine Physicals, Well Baby	100%	100%	100%	50% after ded
Physician Office Visit				
Primary Care	$35 copay	$25 copay	$20 copay	50% after ded
Specialists	$70 copay	$50 copay	$40 copay	50% after ded
Emergency Room Visit				
True Emergency (copay waived if admitted)	80% after $300 copay	80% after $300 copay	80% after $300 copay	80% after $300 in-network copay
Non-Emergency	50% after $300 copay	50% after $300 copay	50% after $300 copay	50% after $300 copay & ded
Hospital				
Inpatient	80% after $300 per admit	80% after $200 per admit	80% after $100 per admit	50% after $300 per admit
Outpatient Services	80% after ded	80% after ded	80% after ded	50% after ded – Shannon facilities are excluded from coverage
Diagnostic/Additional Services				
Lab and X-Ray	$35 copay covered at 80%	$25 copay covered at 100%	$20 copay covered at 100%	50% after ded 50% after ded
CT, MRI, PET, etc	80% after ded	80% after ded	80% after ded	50% after ded
Skilled Nursing	100% 25 visits per calendar year	100% 25 visits per calendar year	100% 25 visits per calendar year	50% after ded 25 visits per calendar year
Home Health Care	100% 60 visits per calendar year	100% 60 visits per calendar year	100% 60 visits per calendar year	50% after ded 60 visits per calendar year
Durable Medical Equipment	80% coinsurance	80% coinsurance	80% coinsurance	50% coinsurance
Hospice Care	100%	100%	100%	50% after ded
Mental Illness/Chemical Dependency				
Inpatient	80% after $300 30 days max per calendar yr	80% after $200 30 days max per calendar yr	80% after $100 30 days max per calendar yr	50% after $300 30 days max per calendar yr
Outpatient Services	$70 copay 30 visits max per calendar yr	$50 copay 30 visits max per calendar yr	$40 copay 30 visits max per calendar yr	50% after ded 30 visits max per calendar yr
Chemical Dependency	3 series of treatments per lifetime			3 series of treatments per lifetime

Prescription Drug Coverage

If you enroll in one of the City of San Angelo health plans, you will automatically receive prescription drug coverage through Aetna. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

All pharmacy benefits are subject to a $200 annual deductible.

Retail (30-day supply)	Amount You Pay at a Participating Pharmacy
Generic:	$15 copay
Preferred Brand:	$60 copay
Non-Preferred Brand:	$100 copay

Members have the option of electing a 90 day supply through a retail pharmacy for maintenance medications.

Mail Order Program (3 month supply for the cost of 2 months)

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications that you take on a regular basis (maintenance medications). Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor with your preferred method of payment. Mail order forms are available from your HR Department or on the Aetna Web site at www.aetna.com.

Mail Order (90-day supply)	Amount You Pay
Generic:	$30 copay
Preferred Brand:	$120 copay
Non-Preferred Brand:	$200 copay

Step Therapy

Coverage for certain designated prescription drugs may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications that may be less costly for you prior to those medications on the step therapy list of drugs being covered under the Plan. A list of step therapy medications and possible alternatives are available to you and your provider on the Aetna website at http://www.aetna.com/individuals-families-health-insurance/document-library/pharmacy/2019-rx-step-program.pdf

Note: The list of eligible drugs in the formulary is subject to change from year to year so check the list to ensure your medication is still listed.

Medical Frequently Asked Questions

Question: I went in for a preventive care visit that was supposed to have no charge. Why did I get charged copay or receive a bill later?
Answer: During a preventive care visit, you may receive both preventive and non-preventive care services. If so, you'll probably be charged for the non-preventive diagnostic treatment or services. For example, during a routine physical exam your doctor might decide that a mole needs to be removed for testing. Because mole removal is considered non-preventive, you'd probably have to pay a copay, coinsurance, or deductible payment for this procedure.

Question: Are Colonoscopies covered under preventive care with no out of pocket expense?
Answer: Colonoscopies are covered expenses if you are age 50 and older when recommended by your physician. Services are covered every 10 years for persons at average risk for colorectal cancer (unless your physician orders on a more frequent basis, not to exceed 2 tests during a 10 consecutive year period). However, like any preventive service, if the visit becomes more than preventive in nature (for example, finding and removing a polyp) you will likely pay a copay, coinsurance, or deductible payment for this procedure.

Question: What is an out-of-pocket limit?
Answer: An out-of-pocket limit is the amount a member must pay out before the plan pays at 100% for eligible expenses. Not all services are subject to an out-of-pocket limit before the plan pays at 100% such as an office visit. Please refer to your benefit plan summaries for the out of pocket limits for each benefit plan.

Question: What is a deductible?
Answer: A deductible is the amount a member must pay out of his/her pocket for expenses before the plan pays out for eligible expenses. Not all services are subject to a deductible such as an office visit. For example, on the Low Plan, the individual deductible is $2,000, and the family deductible is $5,000. Any one individual in the family can meet the individual deductible of $2,000 before the plan pays 80% coinsurance for eligible expenses for that one individual or any combination of family members together can meet the family deductible of $5,000 (all deductible expenses accumulated together to total $5,000) before the plan pays 80% coinsurance for eligible expenses for all family members for specific services such as hospitalization.

Question: What is coinsurance?
Answer: Coinsurance is the percent at which the plan pays and an employee pays for eligible expenses. The Plan pays at 80% coinsurance and an employee pays at 20% coinsurance. Not all services are subject to coinsurance such as an office visit.

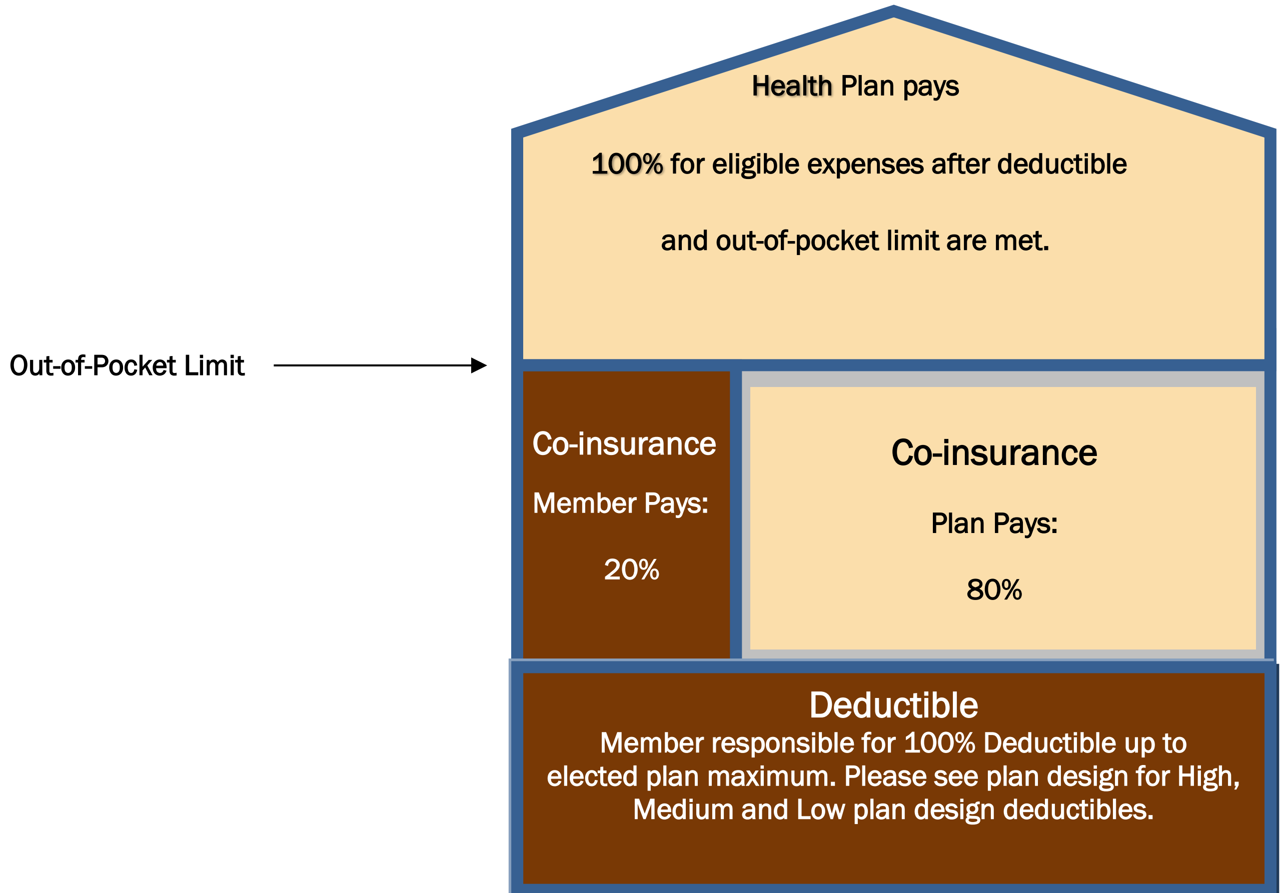
Question: Do copays apply to the out-of-pocket limit?
Answer: Yes, copays do apply towards the deductible or out-of-pocket limit.

Question: What types of services are subject to a copay?
Answer: Services such as office visits are subject to a copay. Prescriptions are also subject to a copay.

Question: What types of services are subject to a deductible, coinsurance and an out-of-pocket limit?
Answer: Services such as hospitalization and outpatient procedures are subject to a deductible, coinsurance, and an out-of-pocket limit.

DEDUCTIBLE, COINSURANCE & OUT-OF-POCKET LIMIT SIMPLE ILLUSTRATION

Members are responsible for expenses shaded in brown, and the plan is responsible for expenses shaded in tan. After copay payment, the plan pays 100%. Copays apply toward a deductible, coinsurance, or an out-of-pocket limit.



Be Your Own Health Care Advocate

Without a doubt, communication is crucial to good health care. When people take an active role in their care, research shows they fare better – in satisfaction and in how well treatments work. A passive patient is less likely to get well. Speaking up and asking questions can improve the quality of your health care, control cost and inconvenience, and reduce your anxiety about the care you receive.

The City of San Angelo is a self-funded plan, meaning the City pays claims out-of-pocket from collected employee premiums and City funding. Dollars are only paid out when claims actually occur; which means ***our benefits and contributions are based on how well our plan runs.***

An overall improvement in employee health or an individual choosing a lower cost treatment option can lead to an immediate reduction in claims. Over time, this helps to fight medical increases in the market, and allows the City to continue to offer lower cost, higher quality health benefits. Following are three steps on how you can help.

1. Form a partnership with your health care provider.

- Find the right health care provider - - Consider the provider's training, experience, willingness to talk on the phone, urgent care, communication and listening skills, and personality.
- Get appropriate immunizations and screenings (mammogram, colonoscopy, Pap smear, PSA). Manage minor health problems on your own. Monitor health problems, and write down your symptoms and when they started, level of discomfort, worsening factors, and previous treatment.
- Write down your main concerns about your health and bring your notes with you to your visit.
    - Bring a list of all of your medications
    - Tell the health care provider your biggest concern first
    - Tell the health care provider if you do not understand something
    - Even if they are uncomfortable or embarrassing, answer all questions honestly

2. *Communicate with your health care provider.*

- Ask questions if a diagnosis, tests, treatments, and medications are not clear to you
- Ask about alternatives
- Share in your treatment - - Report both bad and good reactions, failure to benefit from treatment or inability to comply with treatment to your health care provider.
- Share in decisions about tests - - Ask questions: What will this cost me, what will this cost my health plan, what are the risks, how accurate is it, will it change my treatment, are there alternatives?
- Share in decisions about surgery - - Ask questions: surgeon's experience, description of procedures, least invasive alternatives, success rate of surgery, risks, full recovery time, how to prepare, is it possible to avoid general anesthetic?

3. Be thoughtful about your health care.

- Use a primary care provider for your first stop non-emergency care
- Use specialists for special problems, unclear diagnoses, or special procedures that your primary provider does not do
- Avoid duplicate tests by sending records to specialists and back to your primary care provider, including when you visit the emergency room and hospital
- Use emergency services wisely

Dental Plan

The City's Dental Plan is insured by Delta Dental Insurance Company and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings and orthodontia.

DPO Plan from Delta Dental*

The DPO (Dental Provider Organization) plan allows you the freedom to visit any dentist, without referrals, for all your dental care. If you receive care from one of Delta Dental's in-network dentists, you'll generally pay less for your care. If you choose an out-of-network dentist, your share of costs are usually higher and you may need to file your own claims. For a list of network dentists, go to www.deltadentalins.com and click on the Delta Dental PPO network in the "Find a Dentist" section.

*Delta Dental PPO is Delta Dental's preferred provider organization plan. In Texas, Delta Dental offers a dental provider organization (DPO) plan.

Delta Dental Premier Plan Highlights

Plan Feature	DPO Low Plan	DPO High Plan
Annual Calendar Deductible ■ Individual ■ Family	 $50 $150	 $50 $150
Annual Calendar Benefit Maximum	$1,000	$1,500
Preventive Services (Exams, x-rays, routine cleanings, fluoride treatments)	100% (no deductible)	100% (no deductible)
Basic Services (Endodontics – root canals, Periodontics – gum treatment, sealants, fillings, extractions)	80% (after deductible)	80% (after deductible)
Major Services (Prosthodontics - crowns, inlays, onlays, bridges and dentures)	50% (after deductible)	50% (after deductible)
Orthodontia **Adult** **Dependent children to age 26**	 Not Covered 50%, up to $1,000	 50%, up to $1,500 50%, up to $1,500

You will not need a dental ID card to receive dental services.

Vision Plan

The City's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Superior Vision.

Vision Coverage

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the Superior Vision network, you will receive a benefit allowance on services. To find a network provider, go to www.Superiorvision.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You will pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Plan Feature	Low Plan	High Plan	Non-Network (Plan Allowance)
Eye Exam – Once every 12 months	100% after $10 copay	100% after $10 copay	Up to $47 after $10 copay
Lenses – Every 12 months	Polycarbonate lenses paid in full after $25 copay for: Single Vision, Standard Bifocal, Standard Trifocal or Standard Lenticular Lenses	Polycarbonate lenses paid in full after $25 copay for: Single Vision, Standard Bifocal, Standard Trifocal or Standard Lenticular Lenses	Polycarbonate: Up to $20 Single vision: Up to $48 Bifocal: Up to $69 Trifocal: Up to $85 Lenticular: Up to $125.00 **$25 copayment applies**
Frames - Every 24 months	Up to $125 retail	Up to $150 retail	Up to $45 retail
Contact Lenses – Every 12 months**	Up to $125 retail Medically Required Paid in full **$25 copayment applies**	Up to $150 retail Medically Required Paid in full **$25 copayment applies**	Up to $105 retail Medically required up to $210 retail **$25 copayment applies**
Laser Vision Correction***	$250 allowance	$250 allowance	$250 allowance

**Contact lenses and related professional services (fitting evaluation, and follow-up) are covered in lieu of eyeglasses. Coverage to include all contact lens types (i.e., standard daily wear, extended wear, disposable, toric, gas permeable and bifocal).

***In Lieu of Eyewear Benefit.

Required Health Coverage Notices

For Your Files

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

The notices included in this brochure are:

- *Notice of Privacy Practices* that explains how the City of San Angelo group health plans protect your personal medical information.

- *Medicare Prescription Drug Notice* that explains how the prescription drug coverage under the City of San Angelo health care plans is affected when a participant becomes eligible for Medicare.

- *COBRA Rights Notice* that explains when you and your family may be able to temporarily continue coverage under the City of San Angelo health plans if coverage would otherwise end for you.

- *Newborns & Mothers Health Protection Notice* that describes the coverage provided by law for maternity hospital stays.

- *Women's Health and Cancer Rights Act* that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.

- *Expanded Coverage for Women's Preventive Care* that explains how City of San Angelo covers women's preventive care, including contraceptives, under the Affordable Care Act.

- Notice of "Grandfathered Health Plan" Status that describes how City of San Angelo's plan is classified under the Affordable Care Act and why.

- Notice of Special Enrollment Rights that explains when you can enroll in the plan due to special circumstances.

- *60-Day Special Enrollment Period* that explains when you can enroll in the plan due to special circumstances.

Notice of Privacy Practices

Group Health Plan 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. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.

Health care operations mean such business-related activities as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Human Resources Director:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.

We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the Office for Civil Rights.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Medicare Prescription Drug Notice

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 San Angelo 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 San Angelo has determined that the prescription drug coverage offered by The City of San Angelo 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 San Angelo coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current City of San Angelo 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 San Angelo and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you might 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. **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 San Angelo 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: November, 2018
Name of Entity/Sender: The City of San Angelo
Contact/Office: Benefits Representative
Address: 72 W. College, San Angelo TX 76903
Phone Number: 325-657-9265

COBRA Rights Notice

You are receiving this notice because you have recently become eligible for coverage under the City group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the City Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description or contact the City HR Department.

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

What Is COBRA Continuation Coverage?

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

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

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

When Is COBRA Coverage Available?

The City of San Angelo will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, The City of San Angelo will notify the administrator for COBRA continuation coverage, of the qualifying event:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For the following qualifying events, you or a family member must notify the City of San Angelo HR Department within 60 days after the qualifying event occurs:

- Your divorce or legal separation; or
- Your dependent's loss of eligibility for coverage as a "dependent child."

You must notify the City of the qualifying event by calling the City's Benefit Representative at 325-657-9265..

How Is COBRA Coverage Provided?

Once the COBRA administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect continuation coverage on behalf of your spouse and dependent children. Your spouse may also elect continuation coverage on behalf of your dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

- Your death, divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."
- When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:
- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

When the qualifying event is your reduction in hours or your termination of employment and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare eight months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for you and your family up to a total of 29 months at a higher premium if:

You, your covered spouse or your covered dependents (including newborn and newly adopted children) are determined to be disabled, as defined by the Social Security Act, prior to the qualifying event or during the first 60 days of COBRA coverage;
The Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
The disability lasts at least until the end of the 18-month period of continuation coverage; and
The City is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify the City within the first 60 days of COBRA coverage.
You, your covered spouse or your covered dependents must notify the City within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify the City of the disability determination, call the City's Benefit Representative at 325-657-9265.

You, your covered spouse or your covered dependents must notify the City within 30 days of the date the disability ends by calling the City's Benefit Representative at 325-657-9265.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

You, your covered spouse or your covered dependents must notify the City within 60 days after the event occurs in order to receive this additional coverage. To notify the City of the qualifying event, contact the City's Benefit Representative at 325-657-9265.

Events That May Change Continued Coverage

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules if you experience a qualifying change in status. You, your covered spouse or your covered dependents must notify the City's Benefit Representative at 325-657-9265 within 60 days of the qualifying change in status to change your COBRA coverage. See your Summary Plan Description for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18-, 29- or 36-month continuation period. In such case, you must notify the City's Benefit Representative at 325-657-9265 within 60 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage

COBRA coverage will end automatically upon the expiration of the 18-, 29- or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

City stops providing group health benefits;

Premiums are not paid within 30 days of the due date (with the exception of the initial premium which is due within 45 days of your election date); or

A person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable pre-existing condition clause) or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18-, 29- or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the Plan.

Address Information

Be sure to keep your current address information up to date with the City. Doing so is the only way to ensure that important benefit information will reach you.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For More Information

If you have any questions about COBRA continuation coverage, call the City of San Angelo's Benefit Representative at 325-657-9265.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

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 consultations 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.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymph edema.

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the City of San Angelo HR Department.

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, the City provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit
http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html

Notice of "Grandfathered Health Plan" Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the City's Benefit Representative at 325-657-9265. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the City's medical coverage 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 no more than 31 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in the City's medical coverage as long as you request enrollment by contacting the City of San Angelo no more than 31 days after the marriage, birth, adoption or placement for adoption. For more information, contact the City's Benefit Representative at 325-657-9265.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

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 City of San Angelo, 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, 2017. Contact your State for further information on eligibility.

To see if any more states have added a premium assistance program since July 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com**	1-855-692-5447
Alaska (Medicaid)	*Medicaid:* **http://myakhipp.com** *Medicaid Eligibility:* **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx** *E-mail:* **CustomerService@MyAKHIPP.com**	*1-866-251-4861*
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
Colorado (Medicaid)	**http://www.colorado.gov/hcpf**	1-800-221-3943
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/hipp/**	1-877-357-3268
Georgia (Medicaid)	**http://dch.georgia.gov/medicaid** (click on "Health Insurance Premium Payment (HIPP)")	404-656-4507
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* **http://www.hip.in.gov** *All other Medicaid:* **http://www.indianamedicaid.com**	1-877-438-4479 1-800-403-0864
Iowa (Medicaid)	**http://www.dhs.state.ia.us/hipp/**	1-888-346-9562
Kansas (Medicaid)	**http://www.kdheks.gov/hcf/**	1-785-296-3512
Kentucky (Medicaid)	**http://chfs.ky.gov/dms/default.htm**	1-800-635-2570
Louisiana (Medicaid)	**http://dhh.louisiana.gov/index.cfm/subhome/1/n/331**	1-888-695-2447
Maine (Medicaid)	**http://www.maine.gov/dhhs/ofi/public-assistance/index.html**	1-800-442-6003 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**http://www.mass.gov/MassHealth**	1-800-462-1120
Minnesota (Medicaid)	**http://mn.gov/dhs/ma/**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**	1-800-694-3084
Nebraska (Medicaid)	**http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx**	1-855-632-7633
Nevada (Medicaid)	**http://dwss.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**http://www.dhhs.nh.gov/oii/documents/hippapp.pdf**	603-271-5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**http://www.nyhealth.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**http://www.ncdhhs.gov/dma**	919-855-4100
North Dakota (Medicaid)	**http://www.nd.gov/dhs/services/medicalserv/medicaid/**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://www.oregonhealthykids.gov** **http://www.hijossaludablesoregon.gov**	1-800-699-9075
Pennsylvania (Medicaid)	**http://www.dhs.pa.gov/hipp**	1-800-692-7462
Rhode Island (Medicaid)	**http://www.eohhs.ri.gov/**	401-462-5300
South Carolina (Medicaid)	**http://www.scdhhs.gov**	1-888-549-0820
South Dakota (Medicaid)	**http://dss.sd.gov**	1-888-828-0059
Texas (Medicaid)	**http://www.gethipptexas.com/**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **http://health.utah.gov/medicaid** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**http://www.greenmountaincare.org/**	1-800-250-8427
Virginia (Medicaid and CHIP)	*Medicaid:* **http://www.coverva.org/programs_premium_assistance.cfm** *CHIP:* **http://www.coverva.org/programs_premium_assistance.cfm**	*Medicaid:* 1-800-432-5924 *CHIP:* 1-855-242-8282
Washington (Medicaid)	**http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx**	1-800-562-3022, Ext. 15473
West Virginia (Medicaid)	**http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx**	1-877-598-5820, *HMS Third-Party Liability*
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf**	1-800-362-3002
Wyoming (Medicaid)	**https://wyequalitycare.acs-inc.com/**	307-777-7531

Notes:

The City of San Angelo

This guide highlights the main features of many of the benefit plans sponsored by the City of San Angelo. 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.