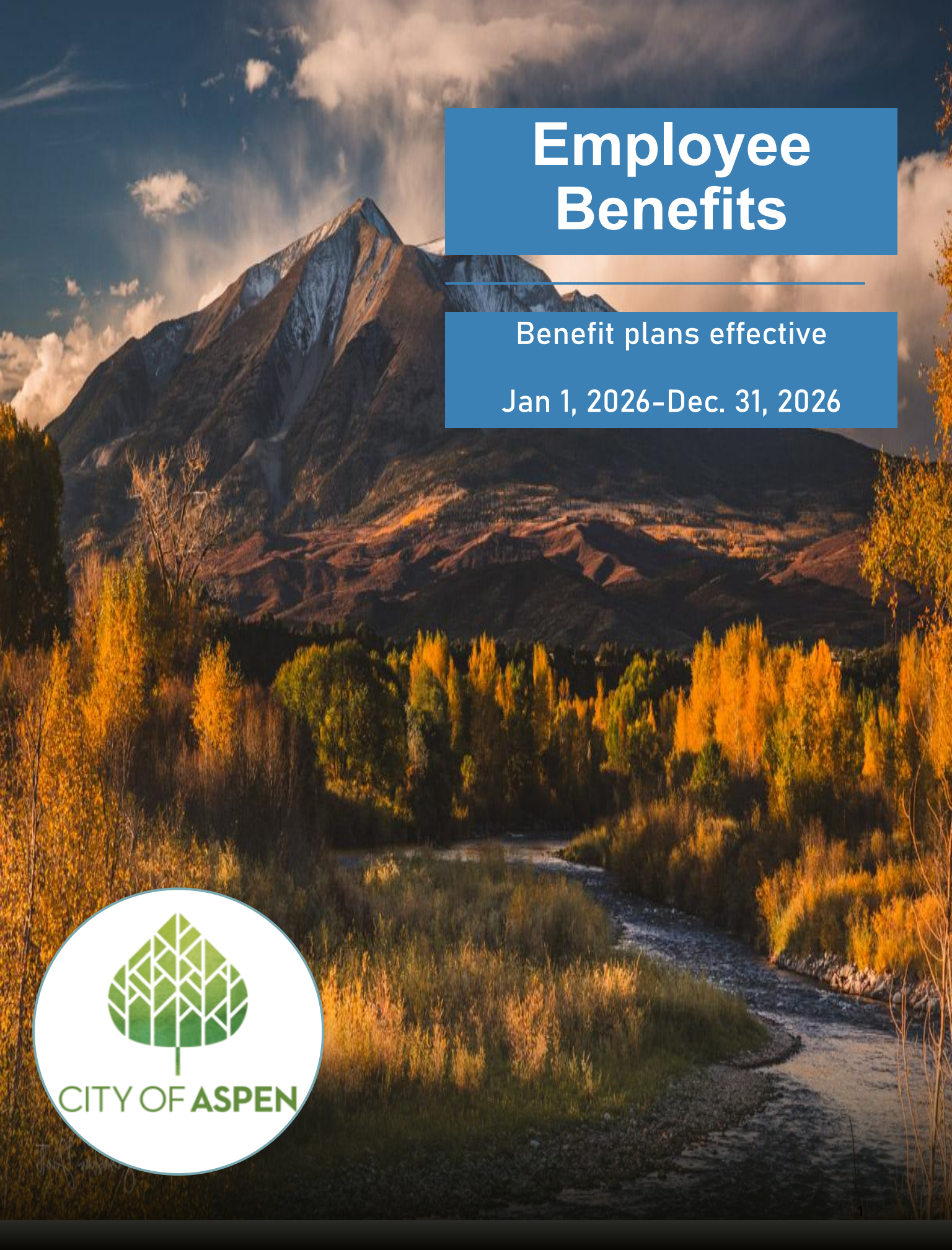


Employee Benefits

Benefit plans effective

Jan 1, 2026–Dec. 31, 2026

CITY OF ASPEN

Table of Contents

Total Compensation Philosophy

The City of Aspen's Total Compensation Philosophy provides a framework to guide decision-making on compensation and benefits programs for employees. As an employer of choice, the City encourages an engaged and innovative workforce through a Total Compensation Philosophy that supports highly competitive and equitable pay. Employees that embody the City's values and mission enjoy a unique and rewarding mountain culture experience.

Example City of Aspen Total Compensation Package	
Employee Gross Pay	$54,642
City Retirement Contribution (6% of pay)	$3,279
City Paid Health Insurance Premium (HDHP HSA Medical Plan)	$13,989
City Funded HSA	$500
Cafeteria Benefit	$2,000
Wellness Program	$250
Total Compensation	**$74,660**

The City of Aspen
Benefits Package.

At City, we are committed to a generous and comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work- life balance. In this guide, you will find important information on the health and well-being benefits available to you for the 2026 plan year.

Please take a moment to review the benefits City offers to determine which plans are best for you. The choices you make upon enrollment will remain the same through December 31, 2026. This excludes the health savings account (HSA), 457(b) retirement plan contributions.

Your benefits package includes

- Medical Benefits
- Dental Benefits
- Vision Benefits
- Flexible Spending Accounts
- Health Savings Account
- Wellness Program
- Disability Insurance
- Life Insurance
- Retirement Benefits
- Cafeteria Plan

Your Benefits Eligibility

Understanding your eligibility for benefits is the first step to investing in your total well-being and unlocking the full potential of the total rewards package that City of Aspen offers to our employees

Eligibility for benefits is determined by the number of hours you are scheduled to work

- ✓ If you are scheduled to work at least 30 hours per week as a regular full-time employee, you are eligible for Life Insurance and Disability Insurance coverage.
- ✓ If you average at least 30 hours worked per week, and have regular full-time status, you may be eligible for Medical, Dental, Vision, and Flexible Spending Account (FSA) coverage for yourself and your dependents.

Employee	Dependents	Waiting Period
Full-time employees working at least 30 hours per week	Your legal spouse including common-law Dependent children may be covered until age 26	1st of the month following date of hire for Medical, Dental, Vision, Flexible Spending Account and Life & Disability Date of hire for Wellness Program, EAP and Retirement Plans

If you do not enroll when you are eligible or decline benefits, you'll receive the following employer sponsored benefits:

- ✓ Short-Term Disability Insurance
- ✓ Long Term Disability Insurance
- ✓ Group Life/AD&D Plan
- ✓ Wellness Program
- ✓ Employee Assistance Program
- ✓ Cafeteria Plan

Enrolling in Benefits

If you are a new employee...

Welcome to the City of Aspen Team! As a new employee, you must enroll in benefits within 30 days of your date of hire. If you do not enroll within 30 days, you will need to wait until the next open enrollment period to enroll.

If you are a current employee...

Open enrollment is the only time during the year that you can change your benefits unless you experience a qualifying life event (see the section below for more information on qualifying life events). During the open enrollment period, you have the opportunity to newly enroll in coverage and/or make changes to your current coverage.

If you wish to contribute pre-tax dollars to a flexible spending account in 2026, you must make a new election during open enrollment. FSA elections do not carry over from year to year.

Any changes you make during open enrollment become effective January 1.

The choices you make at this time will remain in place through December 31, 2026. If you do not sign up for benefits during your initial eligibility period or during the open enrollment period, you will not be able to elect coverage until the following plan year, unless you experience a qualified qualifying life event.

2026 Benefit Enrollment is active. This means you MUST elect your benefits in Oracle even if you don't want to change anything.

Note: This restriction does not apply to the health savings account (HSA), 457(b) retirement plan, or transportation flexible spending account (FSA), which allow you to change your contribution at any time during the plan year

Changing Your Benefits During The Year

You must submit your election changes consistent with your life event within 30 days of the qualifying life event taking place. You may be required to provide proof of the event, such as a marriage license or birth certificate.

What is a Qualifying Life Event?

You cannot change your benefits during the year unless you experience a qualifying life event. The most common qualifying life events are:

- Marriage, legal separation or divorce
- Birth, adoption or change in legal custody of eligible child(ren)
- Death of your spouse or covered child
- Loss of other coverage (e.g., child turns 26 and loses coverage through parent's plan)

Keep in mind, there are other, less common, life events that will allow you to change your benefit election during the plan year. Please contact Human Resources for a complete list of qualifying life events.

If you experience a qualifying life event and wish to change your benefit elections, you must You must let HR know within 30 days of the life event. You may be required to provide proof of your life event, such as a birth certificate or marriage license. You may only modify your benefit elections that are directly impacted by the life event.

EXAMPLE

If you get married, you can add your new eligible spouse to the medical plan, but you cannot change which plan you elect.

Medical Plan – HDHP with HSA

The table below summarizes the key features of our HDHP medical plan option. The coinsurance amounts listed reflect the amount you pay.

	Tier 1: Discount Local Providers	Tier 2: Standard Providers
Deductible (individual/family)	$2,000 / $4,000	$2,500 / $4,500
Out-of-pocket Max (individual/family)	$5,000 / $10,000	$5,500 / $10,500
City HSA Contribution (individual/family)	**$500/$1,000 to your health savings account (HSA)**	
Preventive Care	Plan pays 100%; deductible waived	Plan pays 100%; deductible waived
Primary Care Office Visit *Includes Behavioral Health*	20% after deductible	30% after deductible
Specialist Office Visit	20% after deductible	30% after deductible
Emergency Room	30% after deductible	
Urgent Care	20% after deductible	30% after deductible
Laboratory and Imaging	20% after deductible	30% after deductible
Hospitalization	20% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	30% after deductible
Outpatient Rehabilitation	20% after deductible	30% after deductible
Prescription Drugs	20% after deductible	
Tier 3: Out-Of-Network Benefits		
Deductible (individual/family)	$3,000 / $5,500	
Out-of-pocket Max (individual/family)	$6,000 / $11,000	
Coinsurance for all Services	50% after deductible	

Discount Local Providers

- Aspen Medical Care
- Aspen Valley Health
- Grand River Hospital
- Steadman Clinic Basalt

Standard Providers

- All other in-network Cigna providers

Out-Of-Network

- All Other Providers

Medical Plan – HRA Plan

The table below summarizes the key features of our HRA medical plan option.

	Tier 1: Discount Local Providers	Tier 2: Standard Providers
Deductible (individual/family)	$2,500 / $5,000	$3,500 / $6,500
Out-of-Pocket Max (individual/family)	$5,500 / $11,000	$6,000 / $11,500
City HRA Contribution (individual/family)	**$600/$1,200 to your HRA**	
Preventive Care	Plan pays 100%; deductible waived	Plan pays 100%; deductible waived
Primary Care Office Visit *Includes Behavioral Health*	$35 copay	$40 copay
Specialist Office Visit	$45 copay	$50 copay
Emergency Room	$200 copay then 30% after deductible	
Urgent Care	$45 copay	$50 copay
Laboratory and Imaging	20% after deductible	30% after deductible
Hospitalization	20% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	30% after deductible
Outpatient Rehabilitation	$35 copay	$40 copay
Prescription Drugs	Generic: $10 copay / Preferred Brand: $50 + 20% / Non-Preferred Brand: $100 / Specialty: 25% to $500 maximum	
Tier 3: Out-Of-Network Benefits		
Deductible (individual/family)	$6,500 / $12,500	
Out-of-pocket Max (individual/family)	$11,500 / $22,500	
Coinsurance for all Services	50% after deductible	

Discount Local Providers

- Aspen Medical Care
- Aspen Valley Health
- Grand River Hospital
- Steadman Clinic Basalt

Standard Providers

- All other in-network Cigna providers

Out-Of-Network

- All Other Providers

What is a Tiered Medical Plan?

When selecting where to get care for you and your family, it's important to consider various factors. Starting in 2026, City is implementing a 3-tiered medical plan. Meaning you will see the lowest costs when you chose a Tier 1 or Tier 2 provider.

LOWEST COST ➔ HIGHEST COST

Tier 1
Discount Local Providers

- Aspen Medical Care
- Aspen Valley Health
- Grand River Hospital
- Steadman Clinic Basalt

Tier 2
Standard Providers

- In-Network Providers not listed in Tier 1
- Includes Valley View Hospital

Tier 3
Out-Of-Network

- All Other Providers

The choice is still yours, all tiers are available and you will always have the flexibility to chose what's right for you and your family.

How Tiers Work For You

Tier 1 – Discount Local Providers

- Lower Deductibles
- Lower Out-Of-Pocket Maximums

Tier 2 – Standard Providers

- All Regular In-Network Providers
- Same Cost Sharing As Current

Tier 3 – Out-Of-Network

- Services subject to deductible and coinsurance
- Highest out of pocket expenses

WHERE TO GO FOR CARE

Tier 1: Discount Local Providers

- Aspen Medical Care
- Steadman Clinic, Basalt
- Aspen Valley Health Hospital & Providers
- Grand River Health Hospital & Providers

How Do Tiers Work?

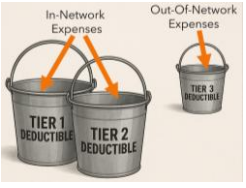
Jeff is a City employee enrolled by himself on the High-Deductible Health Plan. In January he breaks his leg and needs minor surgical repair. He has not yet met any portion of his deductible

	ASPEN VALLEY HOSPITAL	VALLEY VIEW HOSPITAL
AVERAGE COST	$1,678	$3,815
JEFF'S DEDUCTIBLE	$2,000	2,500
JEFF'S ADDITIONAL COST SHARE	$0	30%
JEFF'S TOTAL COST	$1,678	$2,762

Frequently Asked Questions

- *Do I have to see a Tier 1 – Discount Local Providers*
  You will always have the flexibility to choose the right Provider for you and your families. However, when you see a Discount Local Providers your costs will pay the least out-of-pocket expenses.

- *How do the deductibles work?*
  HSA Plan: For an individual, the Tier 1 deductible is $2,000 and Tier 2 is $2,500
  HRA Plan: For an individual, the Tier 1 deductible is $2,500 and Tier 2 is $3,500.



  These cross accumulate which means if you see Tier 2 doctor or a Tier 1 provider the costs you incur count towards both your Tier 1 and Tier 2 deductible.
  Just remember the Tier 1 deductible is lower – so your Tier 1 bucket will fill faster!

- *I love my Doctor and I don't want to change, what do I do?*
  You don't have to do anything! Your flexibility to choose what's best for you is of the utmost importance to City of Aspen. Just remember your costs will be lower when you stay in-network.

- *What happens if my Doctor refers me to a Specialist?*
  You can ask your Doctor to refer you to a Tier 1 Specialist. Between Aspen Valley Health's 5 locations, Grand River Health's 2, and the Steadman Clinic, Basalt, there's likely to be a specialist that fits your needs. You always have the freedom to chose to see a Tier 2 or even out-of-network provider but your costs will be higher.

- *What about Pharmacy?*
  Pharmacy is not impacted by the new Tiering system. We encourage you to take advantage of mail-order to save money but there will not be different deductibles or coinsurance for pharmacy.

- *I have more questions, what do I do?*
  You have a robust benefits team to support you, start with hr@aspen.gov to be directed to the right resource for your needs.

COST COMPARISON FOR JANE
REGULAR (NON-PREVENTIVE) OFFICE VISIT

CITY EMPLOYEE ENROLLED BY HERSELF ON HRA PLAN	ASPEN VALLEY HOSPITAL	VALLEY VIEW HOSPITAL
AVERAGE COST	$177	$515
JANE'S DEDUCTIBILE RESPONSIBILITY	$0	$2,500
JANE'S ADDITIONAL COST SHARE	$40 COPAY	30%
JANE'S TOTAL COST	$40	$515

Jane is a City employee enrolled on the HRA plan by herself. She has met $1,000 of her deductible. She needs to see her doctor for a non-preventive visit.

Get the Most Out Of Your Benefits

Tips and Trick to getting you the best care at the lowest costs

KNOW WHERE TO GO FOR CARE

Need health care right now? Not sure where to go? Start by calling your primary care provider team (PCP). Your PCP knows your health history and can help you assess the urgency of your medical problems and direct you to the best place to receive care.

LEAST EXPENSIVE ← → **MOST EXPENSIVE**

USE TelaDoc TELEHEALTH	GO TO YOUR PCP	GO TO AN URGENT CARE CENTER	GO TO THE EMERGENCY ROOM
When you need care and your doctor's office is closed or you are out of town, try telehealth. All you need is a phone or computer with video. **To get care without leaving your house, make an appointment for:** • Cold and flu symptoms • Rashes • Sinus infections • Urinary tract infections	For care during normal office hours, it's usually best to go to your primary care provider team. They can provide follow-up care and refer you to a specialist, if needed. **Visit your PCP for:** • Preventive care • Non-Emergency illnesses • Treatment of chronic conditions	If you need care now and your PCP is unavailable, try a network urgent care center, which will be faster and less expensive than the ER. **Go to an urgent care center for:** • Small cuts • Minor broken bones	In the case of a true medical emergency, go to the ER or call 911 immediately. **Seek immediate attention at an ER for:** • Chest pain • Sudden weakness or trouble talking • Difficulty breathing • Spinal injuries • Severe head injury • Major broken bones
$	$	$$	$$$

FREE PREVENTIVE CARE

City's medical plans covers preventive care at 100%. This means you will not have to pay anything out of your pocket (no deductible, copay, or coinsurance) for billed preventive services.

What is preventive care?

The focus of preventive health care is to **prevent** illnesses, disease, and other health problems, and to **detect** issues at an early stage when treatment is likely to work best.

Why is preventive care important?

It is important that you have a preventive exam each year— even if you feel healthy and are symptom free—in order to **identify future health risks**.

What's covered?

Covered preventive services **vary by age and gender**. Talk with your provider to determine which screenings, tests, and vaccines will be covered and that are right for you.

Click here for a list of covered preventive services: **Preventive Services**

Pharmacy Programs

Pharmacy costs are not impacted by the new tiering structure

Prescription Home Delivery Program (Mail Order)

Employees enrolled in the CDHP medical plan have access to the Prescription Home Delivery Program (Mail Order) through CVS Caremark® Mail Service Pharmacy. Send medications right to your home or P.O. Box! This means that you can avoid trips to the pharmacy to pick up your medications. Home Delivery or mail order is a convenient option for receiving your long-term (or maintenance) medications that you take on an ongoing basis.

Why use mail order?

- Convenience. Medicine is delivered directly to you, which means fewer trips to the pharmacy. Automatic refill options help you stay on track.
- Safety. All prescriptions are reviewed by a pharmacist to help ensure your order is complete and accurate. Medicine arrives in private, tamper-resistant and when needed, temperature-controlled plain packaging.

How do I start using the Prescription Home Delivery Program?

- Enroll online by registering at Caremark.com/RxDelivery. Please have your address, phone number, drug allergies, and payment information available at the time of registration.
- Request that your doctor submit your prescription to CVS Caremark for a 90-day supply.

Retail 90

At select retail pharmacies you'll be able to pick up a 90-day supply of medication. To locate a pharmacy that participates in this program, please log in to your member portal at Caremark.com and search the pharmacy directory. You're less likely to run out of your medications or miss a dose with 90-day supply and it saves money.

With CVS Caremark you can:

- Transfer your prescriptions online, by phone, or via the Caremark app.
- Receive auto-refill and refill reminders.
- Talk with a pharmacist 24/7.

LEARN MORE!

Visit Caremark.com/HelpCenter for answers to commonly asked questions. In order to have full access to CVS Caremark and manage your prescriptions, register at Caremark.com, or call CVS Caremark at 1-866-818-6911.

Health Savings Account

You must be enrolled in the High-Deductible Health Plan (HDHP) to take advantage of the HSA.

A Health Savings Accounts (HSA) is a pre-tax savings account that belongs to you and is designed to help save money pre-tax for when you have higher health care expenses. Regardless of who puts money into your HSA, HSA dollars are owned by you, the account holder. Unused money rolls over to the next year and is fully portable. This means this is yours in perpetuity.

HSA Eligibility

You are eligible to contribute to an HSA if you are enrolled in the HDHP plan.

You may not fund an HSA if:

- You are enrolled in a non-HSA-eligible medical plan (e.g., your spouse's PPO plan) or a health care FSA
- You are claimed as a dependent on someone else's tax return
- You are enrolled in Medicare, TRICARE, or TRICARE for Life
- You have received Veterans Administration benefits in the previous three months, unless you received treatment for a condition that was/is related to your service
- **If you are enrolled in any Medicare plan, you are not eligible to contribute to a health savings account (HSA). You must stop your HSA contributions when you enroll in Medicare at age 65 or up to six months prior to electing Medicare if you are over age 65. Your contributions may not exceed the prorated amount for the time in which you are eligible to contribute. Excess HSA contributions made while enrolled in Medicare are subject to both income and excise taxes.**

Additional rules apply. Please see IRS Publication 969 for more information.

Coverage Level	2026 HSA ANNUAL CONTRIBUTIONS		
	City HSA Contribution	Your Maximum Contribution	2026 IRS HSA Limits
Employee Only	$500	$3,900	$4,400
Employee + Spouse	$1,000	$7,750	$8,750
Employee + Child(ren)	$1,000	$7,750	$8,750
Employee + Family	$1,000	$7,750	$8,750

Health Savings Account

Qualified HSA Expenses

- Funds in your HSA can be used for your eligible expenses and those of your legal spouse and eligible dependents, even if they are not covered by the City's HDHP medical plan.
- Funds cannot be used for expenses of your domestic partner or their children.
- A complete list of eligible expenses can be found at **irs.gov/pub/irs-pdf/p502.pdf**.
- Utilize your HSA funds through debit card or online bill pay.

Tax Savings and Investment Opportunities

- Contributions to an HSA are tax free and can be made through payroll deductions on a pre-tax basis.
- The money in your HSA (including interest and investment earnings) grows tax free.
- As long as you use the funds to pay for qualified medical expenses, the money is spent tax free.
- Your HSA account can be used as a retirement tool. When you reach the age of 65, you can withdraw for non-medical expenses without penalty - taxes must still be paid.

Your HSA is an Individually Owned Account

- You own and administer your HSA; you determine how much you will contribute to your account and when to use the money.
- You can change your contribution at any time during the plan year without a qualifying event.
- Like a bank account, you must have a balance in order to pay for eligible expenses.
- Keep all receipts for tax documentation.
- An HSA allows you to save and "roll over" money from year to year.
- The money in the account is always yours, even if you change health plans or employers.
- There are no vesting requirements or forfeiture provisions.

HSA Loan

The City of Aspen offers a 0% interest loan to assist employees who are in the HDHP with HSA. If you have suffered an unexpected, catastrophic injury or illness in the first six months of the year, this loan can help and can be paid back through payroll deductions

IF YOU ENROLL IN AN HSA

You cannot contribute pre- tax dollars to a traditional health care FSA. However, you may participate in a limited purpose health care FSA (for dental and vision expenses only). See page 17 for information on FSAs.

Health Reimbursement Account

You must be enrolled in the City of Aspen HRA Plan to take advantage of the HRA

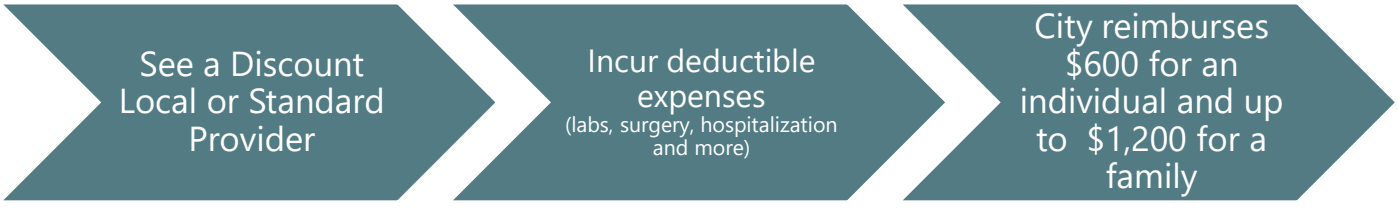
A Health Reimbursement Account (HRA) allows City of Aspen to set aside funds for you to spend on qualified medical expenses. All employees who are enrolled in the HRA medical plan will automatically be eligible for reimbursements under this HRA.

City of Aspen will contribute the following amounts to each employee's account for:

Individual	Family
$600 of Tier 1 or 2 deductible expenses	**$600 per individual, to a maximum of $1,200 of Tier 1 or Tier 2 deductible expenses**

How does it work?

1. You receive services at a Tier 1 or Tier 2 provider that apply toward the deductible. Important note: The HRA will not apply to services that have a copay (such as an office visit or urgent care), since copays do not apply to the deductible.
2. Your provider will submit the medical claim to Allegiance. Allegiance will process the claim and send you and your provider an explanation of benefits.
3. You will pay the provider the amount due on the EOB. If you have elected the health care FSA, you can use the FSA to pay your provider.
4. Allegiance will send you a reimbursement directly.
5. Any unused HRA funds may be carried over for up to one plan-year. The maximum amount that can be carried over is $1,200 for an individual and $2,400 for a family



What do I have to do?

Nothing! There are no forms to fill out or submit to receive HRA reimbursements; Allegiance will automatically send reimbursements directly to you for amounts up to the maximum outlined above.

Dental Insurance

A complete understanding of your dental insurance plan is key to protecting your smile and your wallet.

You have the freedom to choose any provided however contracted providers agree to bill Allegiance directly and to accept a negotiated fee as payment in full. You may be responsible for any additional amounts (also called balance billing). The deductible and annual maximum are on a calendar-year basis and reset every January 1st.

Dental and Vision elections are bundled.
You may elect Dental and Vision coverage IF you are enrolled in one of the medical plans.

Deductible (individual/family)	$50/$150
Annual Benefit Maximum	$2,000
Diagnostic/Preventive Services	Plan pays 100%
Basic Services	20% after deductible
Major Services	50% after deductible
Orthodontia Lifetime Maximum	$2,000
Orthodontia	50%

Frequently Asked Questions

- What is my Dental Network?
  The City provides you an open network dental plan which means there is no network restriction. You can see any provider you wish.
- What is a Basic Service? Major Service?
  Basic services are things like simple extractions and fillings, as well as endodontic treatment such as a root canal. Major services are more complex dental procedures such as a crowns, dental implants or dentures.

Exclusions

This is not a complete list, for a complete list please review the SPD available on City Connect

- X-rays are limited to not more than one full mouth x-ray or series in any three years and not more than two sets of supplementary bitewing x-rays in any one year.
- Charges for temporary dentures
- Charges for hypnosis, prescribed drugs, premedications or any euphoric drugs, except for nitrous oxide
- Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons

Vision Plan

The City offers a unique Vision Reimbursement Plan that gives you freedom and flexibility

What is a Vision Reimbursement Plan?

- A Vision Reimbursement Plan allows you the freedom to chose any provider for your vision needs. Even online providers.
- The City provides each member an annual allowance that can be used on exams or materials.
- You pay your provider in full at time of service and then submit the claim and bill to Allegiance.
- Allegiance than reimburses you up to the annual allowance

Annual Allowance	**$300 per member**
Frequency	Per Calendar Year

What Can I Use My Allowance On?

- Yearly vision exams
- Contact Lenses
- Lenses and Frames

What is Excluded?

This is not a complete list, for a complete list please review the contract available here

- Sunglasses or tinted lenses
- Non-Prescription Lenses
- Medical or Surgical treatment of the eye
- Cosmetic materials, photosensitive or lens coatings.

Where can I get my glasses?

Anywhere you want! There are no network restrictions to the City's vision plan

Dental and Vision elections are bundled.
You may elect Dental and Vision coverage IF you are enrolled in one of the medical plans.

2026 Health Plan Costs

The following monthly contributions are effective January 1, 2026. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis. Deductions are on a bi-monthly basis.

	HIGH-DEDUCTIBLE WITH HSA Non-Tobacco Rates			
Coverage Level	Employee Pays Per-Pay-Period	Employee Pays Monthly	City Pays Monthly	Total Monthly Premium
Employee	$21.22	$42.44	$1,165.77	$1,208.21
Employee & Spouse	$181.31	$362.62	$2,132.50	$2,495.12
Employee & Child(ren)	$164.44	$328.88	$2,041.48	$2,370.36
Employee & Family	$252.24	$504.48	$3,362.95	$3,867.43

	HIGH-DEDUCTIBLE WITH HSA Tobacco Rates			
Coverage Level	Employee Pays Per-Pay-Period	Employee Pays Monthly	City Pays Monthly	Total Monthly Premium
Employee	$62.47	$124.94	$917.16	$1,208.21
Employee & Spouse	$222.56	$445.12	$1,610.86	$2,495.12
Employee & Child(ren)	$205.69	$411.38	$1,507.56	$2,370.36
Employee & Family	$293.49	$586.98	$2,543.46	$3,867.43

	HRA PLAN Non-Tobacco Rates			
Coverage Level	Employee Pays Per-Pay-Period	Employee Pays Monthly	City Pays Monthly	Total Monthly Premium
Employee	$21.22	$42.44	$1,123.48	$1,165.92
Employee & Spouse	$181.31	$362.62	$2,045.17	$2,407.79
Employee & Child(ren)	$164.44	$328.88	$1,958.52	$2,287.40
Employee & Family	$252.24	$504.48	$3,227.59	$3,732.07

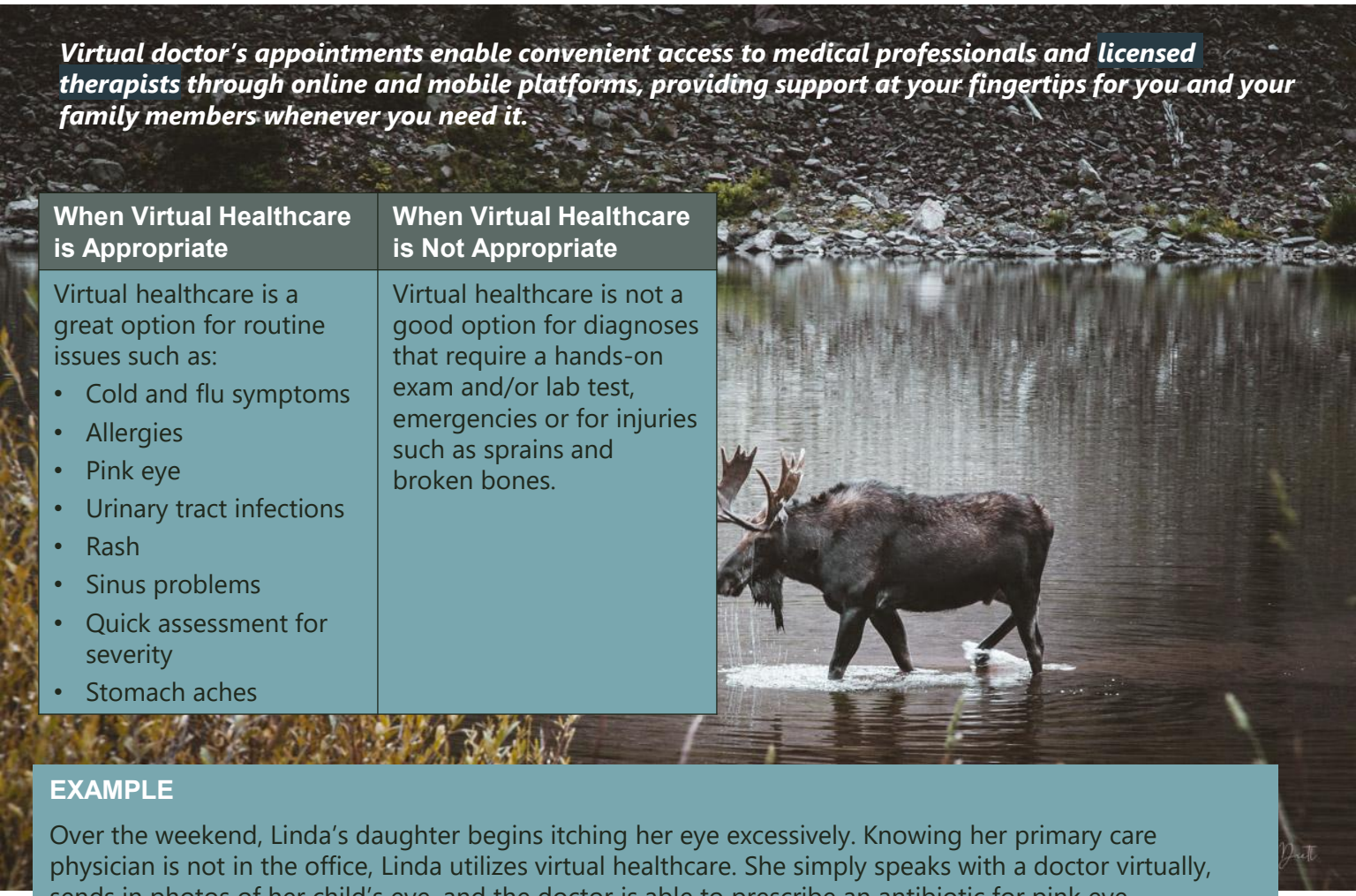
	HRA PLAN Tobacco Rates			
Coverage Level	Employee Pays Per-Pay-Period	Employee Pays Monthly	City Pays Monthly	Total Monthly Premium
Employee	$62.47	$124.94	$917.16	$1,208.21
Employee & Spouse	$222.56	$445.12	$1,610.86	$2,495.12
Employee & Child(ren)	$205.69	$411.38	$1,507.56	$2,370.36
Employee & Family	$293.49	$586.98	$2,543.46	$3,867.43

	DENTAL AND VISION			
Coverage Level	Employee Pays Per-Pay-Period	Employee Pays Monthly	City Pays Monthly	Total Monthly Premium
Employee	$1.10	$2.20	$66.01	$68.21
Employee & Spouse	$2.18	$4.36	$132.02	$136.38
Employee & Child(ren)	$2.04	$4.08	$123.44	$127.53
Employee & Family	$3.29	$6.59	$199.35	$205.93

Teladoc
Virtual Healthcare

Virtual doctor's appointments enable convenient access to medical professionals and licensed therapists through online and mobile platforms, providing support at your fingertips for you and your family members whenever you need it.

When Virtual Healthcare is Appropriate	When Virtual Healthcare is Not Appropriate
Virtual healthcare is a great option for routine issues such as: • Cold and flu symptoms • Allergies • Pink eye • Urinary tract infections • Rash • Sinus problems • Quick assessment for severity • Stomach aches	Virtual healthcare is not a good option for diagnoses that require a hands-on exam and/or lab test, emergencies or for injuries such as sprains and broken bones.



EXAMPLE

Over the weekend, Linda's daughter begins itching her eye excessively. Knowing her primary care physician is not in the office, Linda utilizes virtual healthcare. She simply speaks with a doctor virtually, sends in photos of her child's eye, and the doctor is able to prescribe an antibiotic for pink eye.

Rather than waiting in an urgent care, Linda is able to stay home and care for her daughter!

Teladoc is easy to use!

Register for Teladoc or call (800) 835-2362, 24/7-365 days a year.

- Video chat with a board-certified doctor from your phone, tablet, or computer
- A prescription can be sent to the pharmacy nearest you

Teladoc™ HEALTH

Wellness Program

The City of Aspen cares about your health and wellness. We are proud to offer our full-time employees a comprehensive wellness program that supports your physical, social, financial, and spiritual wellness.

Our Mission
Provide education, tools, and access to a comprehensive wellness program where our employees' health and wellness needs are met, fostering a healthy, engaging and productive workplace culture.

City of Aspen 2026 Wellness Program
Participating in the wellness program can help you monitor your health and learn about overall wellbeing through our monthly educational activities. **Employees are eligible to earn $250.**

Earning Your $250 Reward
Complete the following steps between December 1, 2025, and October 31, 2026.

1. Complete your annual preventive care appointment

2. Complete any of your doctor recommended follow-ups which may include labs.

3. Complete the **self-reporting form** on City Connect.

Wellness incentives will be paid out in December 2026

Reasonable Alternative
If it is unreasonable or medically inadvisable for you to complete these steps within the timeframe provided, please reach out to Human Resources to determine a reasonable alternative standard.

Where can I find mental health support?

The City of Aspen has a variety of resources to support and improve your mental health. If you are experiencing a mental health emergency, call 988.

Are you looking for a virtual tool to improve emotional wellbeing?

Yes →

Headquarters has a Mental Fitness program that aims to improve your wellbeing. Visit: **https://headq.org/headquiz/** to take the headquiz and access a provider directory, workshops, and other resources.

No, I am looking for more support ↓

Are you looking for support for a specific issue like grief, stress, parenting or relationship issues?

Yes →

Utilize your Employee Assistance Program offered through **AllOne Health***. This is a free service which allows full time employees eight counseling visits per issue at **no cost** to you. Part time and intermittent employees are eligible for three no cost visits. Call **877-679-1100 or** visit **www.triadeap.com** and log in with Company Code: City-Aspen to get started.

No, I am looking for more support ↓

Are you looking for mental health care in your area?

Yes →

Use the behavioral health resources provided to you through the **Valley Health Alliance Primary Care Provider**. To find a VHA primary care provider, go to **https://ourvha.org/vha-employer-groups/**

No, I am looking for more support ↓

Are you interested in longer term support and care for conditions like depression and anxiety disorders?

Yes →

Brightside: This program connects you with a licensed therapist. Start by taking the free assessment at **www.brightside.com/askallegiance**

Talkspace: Talkspace matches you with a therapist you can interact with through text or video calls. Visit: **http://www.talkspace.com/allegiance**

Meru: Meru is a 12-week therapy program that offers support through video call, texts, and educational resources. Sign up at: **https://www.meruhealth.com/sign-up/allegiance/**

For therapy visits through Brightside and Talkspace, those on the HRA plan will be charged a $40 copay per visit and those on the HDHP will be charged 30% of the visit cost after their deductible is reached.

Employee Assistance Program

As your employer, we care about your total well-being, which is why we offer an employee assistance program (EAP) through AllOne Health EAP. This program provides counseling services that help you manage problems before they adversely affect your personal life, health, and/or job performance. This benefit is available to all employees of City. Additionally, your legal spouse, domestic partner, and dependent children up to 26 years of age are eligible to participate.

Counselors can help you recognize and successfully address issues including:

- Coping with depression
- Calming anxiety
- Anger management
- Communication issues
- Stress management
- Enhancing relationships
- Marital problems
- Family and parenting issues
- Balancing work and home life
- Sharpening parenting skills
- Working through grief, loss, or trauma
- Improving work relationships
- Coworker conflict
- Substance abuse
- Tackling financial or legal problems

AllOne Health can also help you become your best self by helping you learn how to:

- Set goals
- Improve communication
- Become more resilient

AllOne Health EAP benefits include:

- Mental health counseling
- Financial consultations
- Legal consultations
- Work-life referral service

24-HOUR CRISIS SUPPORT

In the event of a mental health emergency, you have access to an on-call counselor 24-hours a day, 365 days a year.

Triad EAP is a free, strictly confidential service that includes telephonic, virtual, or in-person sessions. Triad EAP is bound by strict confidentiality policies. No names or identifying details are shared with your employer.

Access the EAP 24/7 by calling 877-679-1100 or 970-242-9536.
Or visit https://triad.mylifeexpert.com company code: Aspen

Flexible Spending Accounts

Understanding your Flexible Spending Account options is a key piece to your financial well-being; helping ease your healthcare expenses through tax savings, so your healthcare dollars stretch further.

City offers three flexible spending account (FSA) options— Medical FSA, the limited purpose health care FSA, and dependent care FSA,— which allow you to pay for eligible expenses with pre-tax dollars. The FSAs are administered by Allegiance Benefit Plan Management.

You decide how much to contribute to each FSA on a plan year basis up to the maximum allowable amounts. Your annual election will be divided by 24 pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the year.

Medical Care FSA

The Health Care FSA allows you to set aside money from your paycheck on a pre-tax basis to pay for medical care expenses not covered by the insurance plan or (HRA) with pre-tax dollars.

Some examples include:

- Office Visit and Prescription Copays
- Acupuncture and Chiropractic Care
- Dental, Hearing and Vision Services

The medical care FSA maximum contribution is $3,400 for the 2026 calendar year.

Limited Purpose Health Care FSA

If you fund an HSA

The limited purpose FSA allows you to set aside money from your paycheck on a pre-tax basis for certain IRS-approved dental and vision care expenses not covered or exceed the City's annual benefits by the medical insurance plan. Examples include dental services, orthodontia, vision exams, glasses, and contact lenses. **The limited purpose health care FSA maximum contribution is $3,400 for the 2026 calendar year.**

New Limits! Dependent Care FSA

The dependent care FSA allows you to set aside money from your paycheck on a pre-tax basis for day care expenses. Eligible dependents are children under 13 years of age, or a child over 13, legal spouse, or elderly parent residing in your house who is physically or mentally unable to care for themselves. Examples of eligible expenses are day care facility fees, before- and after-school care, and in-home babysitting fees (income must be reported by your day care provider).

2026 Limits:

- **$7,500 per household**
- **$3,750 per parent if filing separately**

THINGS TO CONSIDER BEFORE CONTRIBUTING

Reminder for Medical Care FSAs: As you make your 2026 FSA election, keep in mind that at the end of the 2026 plan year only $680 of unused funds will carry over into 2027. Any unused funds over $680 will be forfeited. The deadline to submit any 2026 plan year claims is March 31, 2027.

Reminder for Dependent Care FSA: 2026 plan elections will not have any rollover into 2026. The deadline to submit any 2026 plan year claims is April 19, 2027. Any remaining funds after the April 19, 2027 grace period deadline will be forfeited.

- You cannot take income tax deductions for expenses you pay with your FSA(s).
- You cannot stop or change your Dependent Care or Limited Purpose FSA contribution(s) during the plan year unless you experience a qualifying life event.
- If you are enrolled in Medicare, you are eligible to fund a limited purpose health care FSA.
- Funds in these accounts may not be used to pay for insurance premiums.

Basic Life and AD&D Insurance

The City automatically provides basic life and accidental death and dismemberment (AD&D) insurance through Hartford to you, your legal spouse, and your dependent children **at no cost**. You must still make this election when completing your new hire benefits enrollment, and elections changes due to qualifying life events or open enrollment. If you die as a result of an accident, your beneficiary would receive both the life and the AD&D benefit. This benefit is not portable after age 70.

- **Employee***: 1x annual earnings up to $100,000
- **Legal spouse***: $5,000
- **Child(ren):** $1,000

Note: A person may be insured only once under the basic life and AD&D policy as an employee, legal spouse, or dependent child. An employee who is the legal spouse or dependent of another employee may not be insured as both an employee and legal spouse or employee and dependent at the same time. If you are an employee and a dependent, you will be insured as an employee.

*Age reduction schedule applies. If you are still employed, your benefits will reduce to at age 75. Spouse reductions are based on the spouse age. Please see plan document for details.

Voluntary Life and AD&D Insurance

The City provides you the option to purchase additional voluntary life insurance for yourself, your legal spouse, and your dependent children through Hartford

You must purchase voluntary coverage for yourself in order to purchase coverage for your legal spouse and/or dependents. Voluntary life rates are age-banded. Benefits will reduce to 50% at age 75. Spouse reductions are based on spouse age.

- **Employee**: $10,000 increments up to $500,000 or 7x annual salary, whichever is less; guarantee issue: $200,000[1]
- **Legal spouse**: $5,000 increments up to $250,000 or 100% of the employee's election, whichever is less; guarantee issue: $30,000
- **Child(ren)**: $2,000 increments up to $10,000; guarantee issue—$10,000

Medical underwriting is mandatory for amounts over the guarantee issue. If you do not complete the evidence of insurability process with Hartford you will not be approved for life insurance amounts over the guarantee issue amount.

How Does It Work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

This coverage includes a **living benefit** which provides a benefit if you are if you are diagnosed with a terminal illness with less than 12 months to live, you can request 80% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable.

Voluntary Life / AD&D Insurance Costs

Listed below are the monthly rates for voluntary life insurance. The amount you pay is deducted from your paycheck on a post-tax basis. Legal spouse rates and age reductions are based on your legal spouse's age.

	SEMI-MONTHLY VOLUNTARY LIFE / AD&D RATES (24 pay periods)		
Age	**Employee Rate** Per $10,000 of coverage	**Legal Spouse Rate** Per $5,000 of coverage	**Child Rate** Per $2,000 of coverage
<25	$0.400	$0.200	$0.150
25–29	$0.315	$0.158	
30–34	$0.400	$0.200	
35–39	$0.450	$0.225	
40–44	$0.660	$0.330	
45–49	$1.075	$0.538	
50–54	$1.700	$0.850	
55–59	$2.950	$1.475	
60–64	$3.900	$1.950	
65–69	$6.350	$3.175	
70–74*	$12.795	$6.398	
75+*	$12.795	$6.398	
AD&D	$0.150	$0.075	$0.03

THE HARTFORD

Retirement Plans

You have a variety of City sponsored Retirement Savings Options

401(a) Plan

All employees are enrolled in a 401(a) plan to help you save for your future. The City of Aspen contributes 6% of the employee's gross salary to the 401(a) plan, which is fully vested after five years of employment, in increments of 20%. This contribution level increases to 7% at five years and 8% at 10 years.

Year(s) of Service	Percent Vested
0	**0%**
1	**20%**
2	**40%**
3	**60%**
4	**80%**
5 or more	**100%**

City Contributes At Least 6% of Your Salary!

457(b) and Roth 457(b) Plans

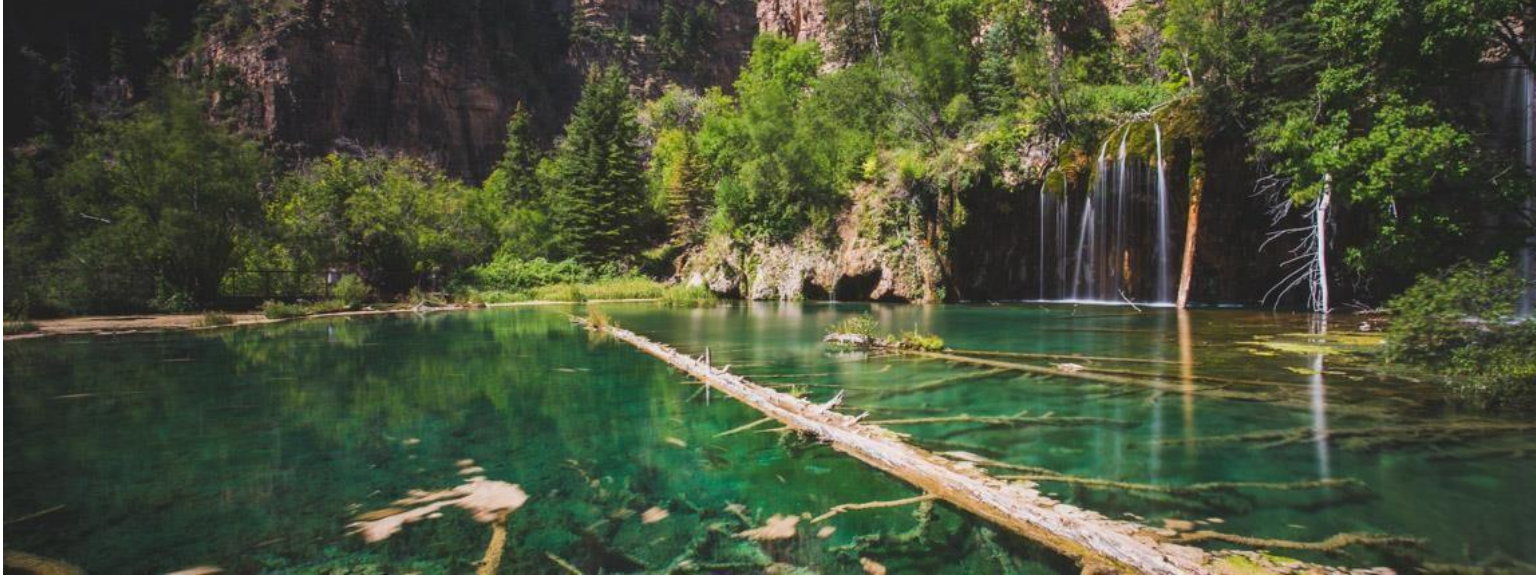
To help you prepare for the future, City of Aspen sponsors a traditional 457 plan and a Roth 457 plan through Mission Square at www.missionsq.org.

Employee Contributions are optional

For 2026, the maximum annual elective deferral for the 457(b) plan is $24,500.
Participants who are age 50 or older may contribute an additional $8,000 through the standard catch-up provision.
Employees between the ages of 60 and 63 are eligible for an super catch-up contribution of $11,500.
The total annual limit on combined employee and employer contributions for governmental 457(b) plans is $72,000.

Police Officers

Police officers are required to contribute 9% of their gross monthly salary to a state approved retirement plan through Mission Square Retirement. The City of Aspen will contribute 10%, which is fully vested after five years of employment, in increments of 20%. After five years the City of Aspen will contribute 11%, and after 10 years, 12%. The City of Aspen also contributes 2.65% to a 457 deferred compensation plan for police officers employed prior to April 1986, and 2.20% for those employed after that date. FFPA retirement program is also mandatory



Disability Insurance

To offer financial protection in the event you are unable to work due to an accident or illness

City of Aspen provides all benefit eligible employees with disability coverage at no cost. If you are unable to perform the essential duties of your job due to sickness, injury or pregnancy, you will receive the benefits outlined below. Employees are eligible for this benefit on their first day of employment. Any disability benefits you receive are taxable, the taxes are automatically withheld from your disability payment from Hartford.

SHORT-TERM DISABILITY

- **Benefit**:
    - Employees with less than 5 years of service: 60% of weekly pay up to $2,000 per week
    - Employees with more than 5 years of service: 70% of weekly pay up to $2,000 per week
- **Elimination period *(when benefits begin)***: On the 15th day, contingent upon satisfying the definition of disability
- **Benefit duration**: Up to 24 weeks

LONG-TERM DISABILITY

- **Benefit**: 60% of monthly pay up to $7,500 per month
- **Elimination period *(when benefits begin)***: On the 181st day, contingent upon satisfying the definition of disability
- **Benefit duration**: Social Security Normal Retirement Age

*Visit **ssa.gov/benefits/retirement/planner/ageincrease.html** to verify your normal retirement age, based on your birth year.

Per the City's policy, an employee **must** utilize ESL, PTO, or Paid Parental Leave if applicable prior to receiving disability benefits. For additional information, refer to the Policy Manual available on City Connect

Travel Assistance

Limitations Apply

Travel Assistance services can help with pre-trip information, emergency medical assistance or personal assistance services while traveling.

Emergency Medical Assistance

- Medical referrals
- Medical monitoring
- Medical evacuation
- Repatriation
- Traveling companion assistance
- Dependent children assistance
- Visit by a family member or friend
- Emergency medical payments
- Return of mortal remains

Pre-Trip Information

- Visa and passport requirements
- Inoculation and immunization requirements
- Foreign exchange rates
- Embassy and consular referrals

For additional information on what is covered, or exclusions and limitations please visit The Hartford at this link

The Hartford

Emergency Personal Services

- Medication and eyeglass prescription assistance
- Emergency travel arrangements
- Emergency cash
- Locating lost items
- Bail advancement

What do I do first?

In the event of a life-threatening emergency, call local emergency authorities first for immediate assistance.

Then, contact Travel Assistance via phone:

U.S. and Canada: **800-243-6108** (toll-free)

Outside U.S.: **202-828-5885**

Or email: **assist@imglobal.com**

Additional Benefits

Cafeteria Options

As part of the benefit package for benefit eligible employees the City of Aspen will contribute an additional $2,000 to employees, through either:

1) Pre-tax options: Health Savings Account (HSA), Medical, Limited Purpose, or Dependent Care Flexible Spending Account (FSA)

2) Post-tax cash option: Regular part-time employees are eligible for half of the dollar amount. Full-time employees working less than 40 hours a week are eligible for a prorated amount based on hours worked.

Effective 1/1/2026 the Cafeteria Benefit is available for all benefit eligible employees according to the above criteria and beginning the first day of the month following the hire date at a prorated amount. Employees may not apply for this benefit after they have notified the City of Aspen of their resignation.

PTO and Extended Sick Leave Accruals

Full-time and part-time employees earn PTO leave starting on their first day of employment. PTO allows for vacation time and sick time to accrue into one flexible bank. ESL is available for an employee once an absence has exceeded 32 hours and a significant health condition for the employee or for an immediate family member is verified.
New employees will earn 22 PTO days, 5 ESL days and 8 holidays in their first year. New police officers will earn 30 PTO days and 5 ESL days in their first year

	Less than 5 Years of Service	**More** than 5 Years of Service
PTO	6.77 hours per pay period	8.62 hours per pay period
PTO: Sworn Police Officers	9.24 hours per pay period	11.08 hours per pay period
ESL	1.54 hours per pay period	1.54 hours per pay period

Holidays

The City of Aspen provides each employee with nine paid holidays per year:
New Year's Day, Martin Luther King Junior Day, President's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

Employee Volunteer / Community Service Leave

After six months of employment, regular full-time employees are eligible to receive up to eight hours of paid leave per calendar year to participate in community service affairs of charitable, education, fraternal, civic, and non-profit organizations in the Roaring Fork Valley.

Additional Benefits

ARC / Aspen Recreation Center Employee Fun Pass

The Employee Fun Pass Benefit Program provides employees and their family members general daily admission into all recreation division facilities and a discount when registering for programmed activities. Daily admission includes: ARC swimming pools, climbing tower, ice-skating on the Lewis Ice Arena and Aspen Ice Garden, shower/locker rooms, adult fitness classes at all facilities (aerobics, yoga, circuit training, etc.).

The employee will need to sign up for and participate in the "Employee Fun Pass Benefit Program" to receive this benefit. The "Employee Fun Pass Benefit Program" entails one person volunteering for a full City of Aspen sponsored special event within one year, for an individual pass, and two people volunteering for one full event or one person volunteering for two full events within one year, for a family pass . Employees are encouraged to sign up for their Fun Pass during Open Enrollment.

City Parks, Aspen Music Festival Passes and Wheeler Opera House Discounts

Employees receive discounts for park use fees for functions (weddings, parties, etc.) and occasional Wheeler Opera House ticket deals. Additionally, Aspen Music Festival passes to the Music Tent are available in the summer, subject to the Aspen Music Festival donating Bearer Passes to the City of Aspen

Employee Golf Pass

Each regular full-time employee is eligible to receive a golf season pass for one person volunteering for a full City of Aspen sponsored special event with the Special Events Department. The pass is only for employees, family members are not eligible. Each regular full-time employee is eligible to receive a golf pass by volunteering for two full City of Aspen special events.

Tuition Reimbursement

Regular full-time employees may receive full or partial reimbursement for tuition and registration fees for preapproved classes leading to a undergraduate or graduate degree deemed to be beneficial to the City of Aspen. The maximum reimbursement is $5,000 per fiscal year per employee dependent of the department's budget.

Transportation

Employees who live outside of Aspen receive free bus passes or zone passes to use the bus system as a means of transportation for commuting to and from work. The City of Aspen also provides the Emergency Ride Home Program through the Transportations Option Program (TOP)

Discounted Verizon Equipment and Packages

Verizon offers discounted equipment and an 18% discount on monthly cell phone plans. Contact IT at help@aspen.gov for additional information

Additional Benefits

Down Payment Homeowner Assistance

All program terms are subject to change.

Purpose: Provide a secured, subordinate loan to assist eligible employees in good standing with the purchase of a primary residence. This benefit is offered on a first-come, first-served basis.

Borrower: Regular full-time employees in good standing with the City of Aspen who own no other residential property within the ownership exclusion zone identified by Aspen Pitkin County Housing Authority (APCHA). One employee loan per household. Human Resources shall approve all loans to evaluate employee eligibility.

Income Limitations: Income limitations and a household's net assets are determined by APCHA ownership guidelines. Currently, a household's net assets shall not exceed $900,000, per APCHA.

Underwriting: Employee must qualify for a primary mortgage that conforms to conventional mortgage underwriting criteria. Employee must demonstrate reasonable capacity to assume all rights and responsibilities associated with the primary mortgage, including, but not limited to: payment of all taxes, insurances, HOA management fees, property maintenance, and repair.

Eligible Properties: Primary residence only. Aspen Pitkin Housing Authority (APCHA) properties and City-owned units only.**Eligible Mortgage Programs:** Employees and co-borrowers must qualify for primary mortgage financing through a reputable lending institution offering terms acceptable to both the employee and the City of Aspen (i.e. a qualified mortgage).

Rental Advance Loan

An employee may apply for an interest free rental advance loan for one-half of the cost to secure a non-city housing unit, including first and last month's rent plus damage deposit. The loan must be repaid in biweekly payroll deductions within one year

Contact Information

PLAN	CARRIER	PHONE	WEBSITE / EMAIL
Medical, Dental & Vision	Allegiance	855-999-1053	Askallegiance.com
Pharmacy	National Cooperative / CVS	877-891-5115	ncrxclientssupport@cvshealth.com
Telehealth Care	Teladoc	800-877-7195	www.teladoc.com
Flexible Spending Arrangement (FSA)	Allegiance	800-877-5176	www.askallegiance.com
Health Reimbursement Arrangement (HRA)	Allegiance	800-877-5176	www.askallegiance.com
Employee Assistance Program (EAP)	AllOne Health	866-470-5733	www.triadeap.com
Health Savings Account (HSA)	HealthEquity	877-245-4077	my.healthequity.com
Wellness Program	Wellness Program	970-987-6475	hr@aspen.gov
Life Insurance and Disability	Hartford	860-547-5000	www.thehartford.com
(457) Retirement Plan	Mission Square	800-669-7400	www.missionsq.org
Benefits Advocacy	IMA	503-592-3415	Jessica.rankin@imacorp.com

ANNUAL HEALTH PLAN IMPORTANT NOTICES

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 3 for more details.

TABLE OF CONTENTS

NOTICE: CMS PART D NOTICE OF CREDITABLE OR NON-CREDITABLE COVERAGE

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.shiphelp.org.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DATE:	1/1/2026
NAME OF ENTITY/SENDER:	City of Aspen
CONTACT--POSITION/OFFICE:	HR Benefits Administrator
ADDRESS:	427 Rio Grande Place
	Aspen, CO 81611
PHONE NUMBER:	(970) 920-5000

NOTICE: SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, 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 stopped contributing towards the other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

NOTICE: HIPAA NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights	**You have the right to:** ❖ Get a copy of your health and claims records ❖ Correct your health and claims records ❖ Request confidential communication ❖ Ask us to limit the information we share ❖ Get a list of those with whom we've shared your information ❖ Choose someone to act for you ❖ File a complaint if you believe your privacy rights have been violated
Your Choices	**You have some choices in the way that we use and share information as we:** ❖ Answer coverage questions from your family and friends ❖ Provide disaster relief ❖ Market our services and sell your information
Our Uses and Disclosures	**We may use and share your information as we:** ❖ Help manage the health care treatment you receive ❖ Run our organization ❖ Pay for your health services ❖ Help with public health and safety issues ❖ Do research ❖ Comply with the law ❖ Respond to organ and tissue donation requests and work with a medical examiner or funeral director ❖ Address workers' compensation, law enforcement and other government requests ❖ Respond to lawsuits and legal action

Your Rights	**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records	❖ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. ❖ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	❖ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. ❖ We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	❖ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. ❖ We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	❖ You can ask us not to use or share certain health information for treatment, payment or our operations. ❖ We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	❖ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. ❖ We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	❖ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	❖ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ❖ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	❖ You can complain if you feel we have violated your rights by contacting us using the information on page 9. ❖ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. ❖ We will not retaliate against you for filing a complaint.
Your Choices	**For certain health information, you can tell us your choices about what to share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:	❖ Share information with your family, close friends, or others involved in payment for your care ❖ Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:	❖ Marketing purposes ❖ Sale of your information

Our Uses and Disclosures	**How do we typically use or share your health information.** We typically use or share your health information in the following ways.	
Help manage the health care treatment you receive	❖ We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	❖ We can use and disclose your information to run our organization and contact you when necessary. ❖ **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	❖ We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your Plan	❖ We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: Your Rights Under HIPAA | HHS.gov.

Help with public health and safety issues	We can share health information about you for certain situations such as: ❖ Preventing disease ❖ Helping with product recalls ❖ Reporting adverse reactions to medications ❖ Reporting suspected abuse, neglect or domestic partner violence ❖ Preventing or reducing a serious threat to anyone's health or safety
Do research	❖ We can use or share your information for health research

Comply with the law	❖ We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	❖ We can share health information about you with organ procurement organizations. ❖ We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: ❖ For workers' compensation claims ❖ For law enforcement purposes or with a law enforcement official ❖ With health oversight agencies for activities authorized by law ❖ For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	❖ We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- ❖ We are required by law to maintain the privacy and security of your protected health information.
- ❖ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ❖ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ❖ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: Your Rights Under HIPAA | HHS.gov.

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Introduction

If you recently gained coverage under a group health plan (the Plan), this notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact person shown at the end of these notices.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work (for fully insured plans issued in California, coverage generally last for 36 months). Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

NOTICE: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

NOTICE (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): PATIENT PROTECTION – PRIMARY CARE DESIGNATION (HMO)

Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

NOTICE (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): PATIENT PROTECTION – OBSTETRICS & GYNECOLOGICAL CARE (HMO)

You do not need prior authorization from your group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, see the contact information at the end of these notices.

NOTICE: GRANDFATHERED HEALTH PLAN

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 plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (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.

NOTICE: PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(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 July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – MEDICAID	COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)
WEBSITE: http://myalhipp.com/ **PHONE:** (855) 692-5447	**HEALTH FIRST COLORADO WEBSITE:** https://healthfirstcolorado.com/ **HEALTH FIRST COLORADO MEMBER CONTACT CENTER:** (800) 221-3943 / STATE RELAY 711 **CHP+:** https://hcpf.colorado.gov/child-health-plan-plus **CHP+ CUSTOMER SERVICE:** (800) 359-1991 / STATE RELAY 711 **HEALTH INSURANCE BUY-IN PROGRAM (HIBI):** https://www.mycohibi.com/ **HIBI CUSTOMER SERVICE:** (855) 692-6442
ALASKA – MEDICAID	**FLORIDA – MEDICAID**
THE AK HEALTH INSURANCE PREMIUM PAYMENT PROGRAM **WEBSITE:** http://myakhipp.com/ **PHONE:** (866) 251-4861 **EMAIL:** CustomerService@MyAKHIPP.com **MEDICAID ELIGIBILITY:** **WEBSITE:** https://health.alaska.gov/dpa/Pages/default.aspx	**WEBSITE:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **PHONE:** (877) 357-3268

ARKANSAS – MEDICAID

WEBSITE: http://myarhipp.com/

PHONE: (855) MyARHIPP (855-692-7447)

GEORGIA – MEDICAID

GA HIPP WEBSITE: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

PHONE: (678) 564-1162, PRESS 1

GA CHIPRA WEBSITE:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra

PHONE: (678) 564-1162, Press 2

CALIFORNIA – MEDICAID

WEBSITE:

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

http://dhcs.ca.gov/hipp

PHONE: (916) 445-8322

FAX: (916) 440-5676

EMAIL: hipp@dhcs.ca.gov

INDIANA – MEDICAID

HEALTHY INSURANCE PREMIUM PAYMENT PROGRAM

ALL OTHER MEDICAID

WEBSITE: https://www.in.gov/medicaid/

http://www.in.gov/fssa/dfr/

FAMILY AND SOCIAL SERVICES ADMINISTRATION

PHONE: (800) 403-0864

MEMBER SERVICES PHONE: (800) 457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

MEDICAID WEBSITE:

Iowa Medicaid | Health & Human Services

PHONE: (800) 338-8366

HAWKI WEBSITE:

Hawki - Healthy and Well Kids in Iowa | Health & Human Services

PHONE: (800) 257-8563

HIPP WEBSITE: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)

PHONE: (888) 346-9562

MASSACHUSETTS – MEDICAID AND CHIP

WEBSITE: https://www.mass.gov/masshealth/pa

PHONE: (800) 862-4840

TTY: 711

EMAIL: masspremassistance@accenture.com

KANSAS – MEDICAID

WEBSITE: https://www.kancare.ks.gov/

PHONE: (800) 792-4884

HIPP PHONE: (800) 967-4660

MINNESOTA – MEDICAID

WEBSITE: https://mn.gov/dhs/health-care-coverage/

PHONE: (800) 657-3739

KENTUCKY – MEDICAID

KENTUCKY INTEGRATED HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (KI-HIPP) WEBSITE:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

PHONE: (855) 459-6328

EMAIL: KIHIPP.PROGRAM@ky.gov

KCHIP WEBSITE: https://kynect.ky.gov

PHONE: (877) 524-4718

KENTUCKY MEDICAID WEBSITE: https://chfs.ky.gov/agencies/dms

MISSOURI – MEDICAID

WEBSITE:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

PHONE: (573) 751-2005

LOUISIANA – MEDICAID

WEBSITE: www.medicaid.la.gov or www.ldh.la.gov/lahipp

MEDICAID HOTLINE: (888) 342-6207

LAHIPP PHONE: (855) 618-5488

MONTANA – MEDICAID

WEBSITE:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

PHONE: (800) 694-3084

EMAIL: HHSHIPPProgram@mt.gov

MAINE – MEDICAID

ENROLLMENT WEBSITE: https://www.mymaineconnection.gov/benefits/s/?language=en_US

PHONE: (800) 442-6003

TTY: Maine Relay 711

PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE:

https://www.maine.gov/dhhs/ofi/applications-forms

PHONE: (800) 977-6740

TTY: Maine Relay 711

NEBRASKA – MEDICAID

WEBSITE: http://www.ACCESSNebraska.ne.gov

PHONE: (855) 632-7633

LINCOLN: (402) 473-7000

OMAHA: (402) 595-1178

NEVADA – MEDICAID

WEBSITE: https://dhcfp.nv.gov/

PHONE: (800) 992-0900

OREGON – MEDICAID

WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx

PHONE: (800) 699-9075

NEW HAMPSHIRE – MEDICAID

WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

PHONE: (603) 271-5218

TOLL FREE NUMBER FOR THE HIPP PROGRAM:

(800) 852-3345 Ext. 5218

EMAIL: DHHS.ThirdPartyLiabi@dhhs.nh.gov

PENNSYLVANIA – MEDICAID

WEBSITE:

https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

PHONE: (800) 692-7462

CHIP WEBSITE: Children's Health Insurance Program (CHIP) (pa.gov)

PHONE: (800) 986-KIDS (5437)

NEW JERSEY – MEDICAID AND CHIP

MEDICAID WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

MEDICAID PHONE: (800) 356-1561

CHIP PREMIUM ASSISTANCE PHONE: (609) 631-2392

CHIP WEBSITE: http://www.njfamilycare.org/index.html

CHIP PHONE: (800) 701-0710 (TTY: 711)

RHODE ISLAND – MEDICAID AND CHIP

WEBSITE: http://www.eohhs.ri.gov/

PHONE: (855) 697-4347 or

(401) 462-0311 (Direct Rite Share Line)

NEW YORK – MEDICAID

WEBSITE: https://www.health.ny.gov/health_care/medicaid/

PHONE: (800) 541-2831

SOUTH CAROLINA – MEDICAID

WEBSITE: https://www.scdhhs.gov

PHONE: (888) 549-0820

NORTH CAROLINA – MEDICAID

WEBSITE: https://medicaid.ncdhhs.gov/

PHONE: (919) 855-4100

SOUTH DAKOTA - MEDICAID

WEBSITE: http://dss.sd.gov

PHONE: (888) 828-0059

NORTH DAKOTA – MEDICAID

WEBSITE: https://www.hhs.nd.gov/healthcare

PHONE: (844) 854-4825

TEXAS – MEDICAID

WEBSITE: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services

PHONE: (800) 440-0493

OKLAHOMA – MEDICAID AND CHIP	UTAH – MEDICAID AND CHIP
WEBSITE: http://www.insureoklahoma.org **PHONE:** (888) 365-3742	**UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP) MEDICAID WEBSITE:** https://medicaid.utah.gov/upp/ **EMAIL:** upp@utah.gov **PHONE:** (888) 222-2542 **ADULT EXPANSION WEBSITE:** https://medicaid.utah.gov/expansion/ **UTAH MEDICAID BUYOUT PROGRAM WEBSITE:** https://medicaid.utah.gov/buyout-program/ **CHIP WEBSITE:** http://health.utah.gov/chip
VERMONT– MEDICAID	**WEST VIRGINIA – MEDICAID AND CHIP**
WEBSITE: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **PHONE:** (800) 250-8427	**WEBSITE:** https://dhhr.wv.gov/bms/ http://mywvhipp.com/ **MEDICAID PHONE:** (304) 558-1700 **CHIP TOLL-FREE PHONE:** (855) MyWVHIPP (699-8447)
VIRGINIA – MEDICAID AND CHIP	**WISCONSIN – MEDICAID AND CHIP**
WEBSITE: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs **MEDICAID & CHIP PHONE:** (800) 432-5924	**WEBSITE:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **PHONE:** (800) 362-3002
WASHINGTON – MEDICAID	**WYOMING – MEDICAID**
WEBSITE: https://www.hca.wa.gov/ **PHONE:** (800) 562-3022	**WEBSITE:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **PHONE:** (800) 251-1269

To see if any other States have added a premium assistance program since July 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)

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and posted electronically.

For more information, contact:

NAME:	1/1/2026
TITLE:	HR Benefits Administrator
ADDRESS:	427 Rio Grande Place
	Aspen, CO 81611
PHONE NUMBER:	970-920-5000

Effective date of this Notice: January 1, 2026