2026

Benefits Guide

Retirees & COBRA

Open Enrollment: October 1 – October 31, 2025
Effective Dates: January 1 – December 31, 2026

CITY OF CHICO
INC. 1872

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Important Notice: Read Carefully

City of Chico has made every attempt to ensure the accuracy of the information described in this enrollment Guide. Any discrepancy between this Guide and the insurance contracts or other legal documents that govern the plans of benefits described in this enrollment Guide will be resolved according to the insurance contracts and legal documents. Nothing in this enrollment Guide will amend, modify, increase, expand, enhance or in any other way alter the terms of the underlying benefit plans as set forth in the insurance contracts and other legal documents that govern them. City of Chico deserves the right to amend or discontinue the benefits described in this enrollment Guide in the future, as well as change how eligible employees and the City of Chico share plan costs at any time for any reason. This enrollment Guide creates neither an employment agreement of any kind nor a guarantee of continued employment with the City.

Welcome to Your Benefits Guide

The benefits in this summary are effective **January 1st, 2026** through **December 31st, 2026**

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, the City of Chico supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

For information about the specific plans available to you, contact the Human Resources and Risk Management Office at **(530) 879-7900** or visit the City's website at:

www.chicoca.gov/Departments/Human-Resources--Risk-Management/Human-Resources/Employee-Benefits/

Notice of Creditable Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next twelve months, a Federal law gives you more choices about your prescription drug coverage. Please review the **Health Plan Notices** tab for detailed information.

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

2026 Open Enrollment

Your benefits should complement your life. During Open Enrollment, reflect upon how your life has changed over the past year and consider how it may be different next year. Then, participate in Open Enrollment and choose benefits that will best serve you in 2026. Open Enrollment for the 2026 plan year begins October 1st and will remain open thru October 31st. The benefits you choose will become effective January 1, 2026.

Remember, Open Enrollment is generally your one time of the year to make changes to your benefits, and you'll need to participate if you want to:

- Make changes to your medical, dental, vision, and voluntary life plans for next year.
- Add/drop eligible dependents.

BCC is the City of Chico's administrator for benefit enrollment. You will have 24/7 online access to your personal dashboard to make your benefits decisions. Information on how to enroll will be provided to you by Human Resources. **See page 5 for enrollment instructions.**

What's New in 2026?

Prescription Benefits – Navitus

- Navitus is replacing *Express Scripts* & *Anthem Pharmacy* as your new Pharmacy Benefit Manager
- Annual formulary and list of excluded medications updates effective January 1, 2026
- All enrollees will be receiving new ID cards.
- Go to navitus.com/members.
- Medicare PDP Rx Out of Pocket Maximum will increase from $2,000 to $2,100

Prescription – Maintenance Medications – Rx 'N Go

- Rx 'n Go is a convenient and cost-saving prescription program that delivers a 90-day supply of maintenance medications directly to your home—at $0 copay.
- See page 23 for information

Medical

- Beginning January 1st, all medical plans will have a zero-cost co-pay for in-network virtual visits.
- The deductible for the Anthem HDHP plan will change $3,400 individual/ $6,800 family.
- When you enroll in one of the PRISM Medical Plans, you have access to enrolling in **Digbi Health**, **Hinge Health** & **Carrum Health**. See page 23 & 24 for more information.

Anthem Total Health Connections: gives you one-on-one support from a dedicated Family Advocate to help you navigate care, benefits, and wellness resources. See page 21 for more information.

Dental

- The City is introducing a new Delta Dental buy-up plan that has a higher calendar year maximum of $2,000. Read more on page 27.

Enrolling for Benefits

What You Need to Do

You will need to make choices about which benefits you'd like to participate in during "enrollment windows." Enrollment windows are specific times that will require you to take action and select your benefits:

- During the annual Open Enrollment period (October 1–October 31). Any changes you make during the Open Enrollment period become effective January 1, 2026.
- If you do not wish to make any changes to your benefits, no further action is necessary.

Get Ready to Enroll

1. Review your options, ask questions and talk with your family. If you're thinking of changing medical plans or you are choosing for the first time:
   a) Check with your doctors to find out which plans they participate in.
   b) If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or non-formulary drugs).
   c) Call the medical plan's Member Services number or visit its website (contact details are on page 34 of this Guide).
2. Consider not only your current circumstances but also what may be happening in your life in the future. Outside of Open Enrollment, you will not be able to make changes to your benefits unless:
   a) You have a QLE or HIPAA special enrollment event (for example, you get married or have a child).
   b) You move out of the network service area.

3. Consider the following when choosing a medical plan:
   a) What the plans cover. The Medical Plans section of this Guide explains what each plan covers.
   b) Your estimated usage. Does your plan choice adequately cover the services you use most or will need in the future?
   c) Flexibility in choice of doctors, hospitals and how you receive care. Each plan may include a different set of doctors or hospitals or have different rules for how to receive care.
   d) Verify service areas and provider availability.

4. Have the right information handy. When you start the enrollment process, you'll need:
   a) Your Social Security number.
   b) The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate. Social Security numbers are required for all dependents over the age of 6 months.
   c) Proof of dependent eligibility (marriage license, domestic partner certification, birth certificate).

Enrolling for Benefits

How to Enroll/Make Changes by Paper Form

To change your medical plan or add/delete dependent coverage, you must submit a City of Chico Retiree Open Enrollment Form selecting the coverage you wish to elect.

If you are Medicare eligible and would like to enroll in the Navitus Medicare (PDP) Medicare Part D program, a Medicare Prescription Plan Benefit Election Form must be completed.

The Application for Benefits and the Medicare Prescription Plan Benefit Election Form can be obtained by contacting BCC. See page 34 for contact information.

How to Submit Completed Forms

Mail to BCC:
Benefit Coordinators Corporation (BCC)
ATTN: Retiree Benefits OE
Two Robinson Plaza, Suite 200
Pittsburgh, PA 15205

Email to BCC: CustomerSupport@benxcel.com

Website: www.benxcel.net

Eligibility & Changes

Eligibility

If you are a Retiree and/or COBRA Beneficiary, you may participate in the benefits described in this guide given you meet the City's eligibility criteria. Please contact BCC for additional information. See page 34 for contact information.

Retiree note: If at the time of your retirement or at any future date, you choose to leave the City's medical plan, you may not re-enroll in the future.

The following dependents are eligible for benefits:

- Legally married spouse (as defined by applicable state law);
- Registered Domestic Partner (Certificate of Registration is required);
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26;
- Children who are disabled and depend on you for support;
- Children named in a Qualified Medical Child Support Order (QMCSO).

Under no circumstances are you allowed to keep dependents (spouses and/or child(ren)) on your benefits if they are no longer eligible. Failure to notify the City of ineligibility within 60 days will result in the forfeiture of their COBRA rights.

If it is discovered that a dependent was kept on the benefits while no longer eligible, they will be terminated retroactively to the date of ineligibility and any claims incurred by them after that date will be the responsibility of the employee. The employee will also not be reimbursed for any premium contribution made on behalf of the ineligible dependents.

Domestic Partner Eligibility Criteria

If you are enrolling a domestic partner, you must have a valid Declaration of Domestic Partnership on file with the State of California.

Note: *The value of health care coverage provided for a domestic partner, or any enrolled dependent children of your domestic partner is treated as income to you for federal tax purposes (and in some cases, state tax purposes). City of Chico will report the value of the coverage as income to you on your Form W-2 and will withhold applicable taxes. The amounts taxable to you can be substantial. It is recommended you consult with your tax advisor for more information on how this affects you.*

Making Changes

You can change your medical benefit plan during annual enrollment. Coverage will remain in effect for the entire plan year (January 1 – December 31, 2026). You cannot change your coverage (i.e., add any family members to your coverage or change plans) during the plan year, unless you have a HIPAA special enrollment event or become Medicare eligible. Please review the separate Health Plan Notices Packet on the website at www.chicoca.gov/Departments/Human-Resources--Risk-Management/Human-Resources/Employee-Benefits

Medical Plans & Prescription Drugs

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review plan documents before selecting a plan.

What you need to know	
Anthem EPO *Anthem Network*	• **For Early Retirees, Retirees Over 65 & COBRA** • Access to in-network providers/facilities exclusively • No primary care physician (PCP) or referrals to see specialist • Predictable costs
Anthem PPO *Anthem Network*	• **For Early Retirees, Retirees Over 65 & COBRA** • Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network services are available but at a higher cost
Anthem HDHP/HSA *Anthem Network*	• **For Early Retirees & COBRA only** • Access to HSA account to offset out-of-pocket costs • Must meet deductible for most services before the plan begins to pay a % of the cost • Out-of-network services are available but at a higher cost
Prescription Drugs	• Included with your medical plan • Generics have the lowest cost, while non-formulary brand-name drugs have the highest. Formularies are regularly updated. • **NEW!** Navitus is the new Pharmacy Benefit Manager for all health plans
Carrum Health	• Access to Center of Excellence hospitals & surgeons through the Carrum Health for certain types surgeries • A dedicated Care Concierge helps with everything from paperwork and medical records to surgeon selection, travel arrangements, and post-surgery care. • Co-insurance and deductibles may be waived for your surgery. (Due to IRS regulation on HDHP plans, the deductible applies but the co-insurance is waived.) • Travel expenses (if applicable) will be covered for the patient and an adult companion. • See page 23 for more information.

Medical Benefit Summaries – Retirees Under 65 & COBRA
Anthem EPO & PPO (90/10)

	Anthem EPO (Navitus Pharmacy)	Anthem PPO (90/10) (Navitus Pharmacy)	
	In-Network Only	In-Network	Out-of-Network
Annual Deductible (Individual / Family)	$250 /$500	None	$500 / $1,500
Annual Maximum Medical (Individual /Family)	$1,250 / $2,500 Includes deductible	$2,000 / $6,000	$5,000 / $15,000
Annual Maximum Pharmacy (Individual /Family)	$5,350 / $10,700	$4,600 / $7,200	Not covered
Physician / Specialist Office Visits	$20 copay (ded waived)	$10 copay	30% after ded
Virtual Visits	No charge (ded waived)	No charge	30% after ded
Preventive Services	No charge (ded waived)	No charge	Not covered
Lab & X-rays	No charge after ded	$10 copay (preventive no chg)	30% after ded*
Advanced Imaging	No charge after ded	10%	30% after ded*
Room & Board Hospital Inpatient	No charge after ded	10%	30%*
Outpatient Surgery	No charge after ded	10%	30% after ded*
Urgent Care	$20 copay (deductible waived)	$10 copay	30% after ded
Emergency Services (copay waived if admitted)	$250 copay; 0% after ded	10%	10%
Ambulance Services	No charge after ded	10%	10%
Skilled Nursing Facility	0% after ded (up to 100 pre-auth days/calendar yr)	10%*	Freestanding SNF: 10%* Hospital SNF: 30%*
Durable Medical Equipment	No charge after ded	10%	30%*
Prescription Drug Copay (Retail Pharmacy: 30-day supply)	$5 G / $10 B / $25 NF (deductible waived)	$5 G / $10 B / $25 NF	Not covered
Prescription Drug Copay (Mail Order: 90-day supply)	$10 G / $20 B / $50 NF (deductible waived)	$10 G / $20 B / $50 NF	Not covered
Specialty (formerly Self-Administered Injectables)	20% up to $100 copay maximum per Rx (ded waived)	30% up to $150 copay maximum per Rx	Not covered
Chiropractic	$20 copay (ded waived) *Up to 30 visits per year*	$25 copay *Up to 12 visits per year*	30% *Up to 12 visits per year*
Acupuncture	$20 copay (ded waived) *Up to 12 visits per year*	$25 copay *Up to 20 visits per year*	$25 copay *Up to 20 visits per year*

*see Summary Plan Description for limitations.
The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Medical Benefit Summaries – Retirees Under 65 & COBRA
Anthem PPO (80/20) & HDHP

	Anthem PPO (80/20) (Navitus Pharmacy)		Anthem HDHP (Navitus Pharmacy)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual / Family)	$250 / $500		$3,400 /$6,800 Deductible applies to all services including prescriptions	
Annual Maximum Medical (Individual /Family)	$3,250 / $6,500 includes deductible	$10,000 / $20,000	$3,400 /$6,800 includes deductible	$5,000 / $10,000 includes deductible
Annual Maximum Pharmacy (Individual /Family)	$3,350 / $6,700	No Limit	Combined with Medical	N/A
Physician / Specialist Office Visits	$25 copay (ded waived)	40% after ded	No charge after ded	50% after ded
Virtual Visits	No charge (ded waived)	40% after ded	No charge (ded waived)	50% after ded
Preventive Services	No charge (ded waived)	Not covered	No charge (ded waived)	Not covered
Lab & X-rays	$25 copay (preventive no charge)	40%* after ded (preventive not cov)	No charge after ded (preventive ded waived)	50% after ded (preventive not covered)
Advanced Imaging	20% after ded	40%* after ded	No charge after ded	50%* after ded
Room & Board Hospital Inpatient	$100 copay then 20%	40% after ded	No charge after ded	50%* after ded
Outpatient Surgery	Hospital: $50 + 20% Ambulatory Center: 20%	40% after ded	No charge after ded	50% after ded
Urgent Care	$25 copay (ded waived)	40% after ded	No charge after ded	50% after ded
Emergency Services (copay waived if admitted)	20% after ded	20% after ded	No charge after ded	No charge after ded
Ambulance Services	20% after ded	No charge*	No charge after ded	No charge after ded
Skilled Nursing Facility	Freestanding SNF: $100 + 20% after ded Hospital SNF: $100 + 20% after ded	Freestanding SNF: 20%* after ded Hospital SNF: 40%*	No charge after ded	Freestanding SNF: 0%* after ded Hospital SNF: 50%* after ded
Durable Medical Equipment	20% after ded	40% after ded	No charge after ded	50% after ded
Prescription Drug Copay (Retail Pharmacy: 30-day supply)	$5 G / $10 B / $25 NF (deductible waived)	Not covered	No charge after ded	Not covered
Prescription Drug Copay (Mail Order: 90-day supply)	$10 G / $20 B / $50 NF (deductible waived)	Not covered	No charge after ded	Not covered
Specialty (formerly Self-Administered Injectables)	30% up to $150 copay maximum per Rx (deductible waived)	Not covered	No charge after ded	Not covered
Chiropractic	$25 copay *Up to 12 visits per year*	40% *Up to 12 visits per year*	No charge after ded *Up to 20 visits per year*	50% *Up to 20 visits per year*
Acupuncture	$25 copay *Up to 20 visits per year*	$25 copay *Up to 20 visits per year*	Not covered	Not covered

*see Summary Plan Description for limitations.
The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Medical Benefit Summaries – Retirees 65 & Older
Anthem EPO & PPO (90/10)

	Anthem EPO (Navitus Pharmacy)	Anthem PPO (90/10) (Navitus Pharmacy)	
	In-Network Only	In-Network	Out-of-Network
Annual Deductible (Individual / Family)	$250 /$500	None	$500 / $1,500
Co-Insurance	50% for certain benefits	10% for most benefits	30% for most benefits
Annual Maximum Medical (Individual /Family)	$1,000 / $2,000 Includes deductible	$2,000 / $6,000 Included deductible	$5,000 / $15,000
Annual Maximum Pharmacy (Individual /Family)	None	None	No limit
Physician / Specialist Office Visits	$20 copay (ded waived)	$10 copay	30% after ded
Preventive Services	No charge (ded waived)	No charge	Not covered
Lab & X-rays	No charge after ded	$10 copay (diagnostic testing: 10%)	30% after ded*
Room & Board Hospital Inpatient	No charge after ded	10%	30%*
Outpatient Surgery	No charge after ded	10%	30% after ded*
Emergency Services (copay waived if admitted)	$250 copay; No charge after ded	10%	10%
Ambulance Services	No charge after ded	10%	10%
Home Health Care	No charge after ded	10%	10% after ded
Skilled Nursing Facility	No charge after ded	10%*	10% after ded
Hospice	No charge after ded	10%*	10% after ded
Durable Medical Equipment	No charge after ded	10%	30%*
Prescription Drug Copay (Retail Pharmacy: 30-day supply)	$5 G / $10 B / $25 NF	$5 G / $10 B / $25 NF	Not covered
Prescription Drug Copay (Mail Order: 90-day supply)	$10 G / $20 B / $50 NF	$10 G / $20 B / $50 NF	Not covered
Specialty (formerly Self-Administered Injectables)	20% up to $100 copay maximum per Rx	30% up to $150 copay maximum per Rx	Not covered
Chiropractic	$20 copay (ded waived) *Up to 30 visits per year*	$25 copay *Up to 12 visits per year*	30% after ded *Up to 12 visits per year*
Acupuncture	$20 copay (ded waived)	$25 copay *Up to 20 visits per year*	$25 copay *Up to 20 visits per year*

*see Summary Plan Description for limitations.
The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Medical Benefit Summaries – Retirees 65 & Older
Anthem PPO (80/20)

	Anthem PPO (80/20) (Navitus Pharmacy)	
	In-Network	**Out-of-Network**
Annual Deductible (Individual / Family)	$250 / $500	
Coinsurance	20% for most benefits	20% for most benefits
Annual Maximum Medical (Individual /Family)	$3,000 / $6,000 includes deductible	$10,000 / $20,000
Annual Maximum Pharmacy (Individual /Family)	None	No Limit
Physician / Specialist Office Visits	$25 copay (ded waived)	40% after ded
Preventive Services	No charge (ded waived)	Not covered
Lab & X-rays	$25 copay (diagnostic testing: 20%)*	40%* after ded (preventive not cov)
Room & Board Hospital Inpatient	$100/admit then 20%	40% after ded
Outpatient Surgery	Hospital: $50 + 20% Ambulatory Center: 20% after ded	40% after ded
Emergency Services (copay waived if admitted)	20% after ded	20% after ded
Ambulance Services	20% after ded	20% after ded
Home Health Care	20% * after ded	20% * after ded
Skilled Nursing Facility	$100 + 20% after ded	20%* after ded
Hospice	20% * after ded	20% * after ded
Durable Medical Equipment	20% after ded	40% after ded
Prescription Drug Copay (Retail Pharmacy: 30-day supply)	$5 G / $10 B / $25 NF	Not covered
Prescription Drug Copay (Mail Order: 90-day supply)	$10 G / $20 B / $50 NF	Not covered
Specialty (formerly Self-Administered Injectables)	30% up to $150 copay maximum per Rx	Not covered
Chiropractic	$25 copay *Up to 12 visits per year*	40% after ded *Up to 12 visits per year*
Acupuncture	$25 copay *Up to 20 visits per year*	$25 copay *Up to 20 visits per year*

*see Summary Plan Description for limitations.
The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Prescription Drugs
All Retirees & COBRA

Your prescription drug coverage is included as part of the medical plan option you select. You should always use a participating pharmacy (one that is contracted by your medical plan) to get the best price.

The medical plans have "tiered" copayments for prescription drugs, meaning you pay a different amount for different classes or groups of drugs. Generic drugs generally have the lowest copays, and non-formulary brand name drugs generally have the highest copays.

IMPORTANT!

Effective January 1st, 2026, Express Scripts and/or Anthem Pharmacy will no longer be the Pharmacy Benefit for the Anthem plan. Anthem members have access to prescription drug coverage through **Navitus**. Below is some information to keep in mind regarding this coverage:

Understanding Your Pharmacy Benefits

Members who take stabilized doses of covered long-term maintenance medications — like those used to treat an ongoing condition such as high blood pressure or high cholesterol — can save money by ordering them through Navitus' mail service partner, Costco Pharmacy, instead of using a retail pharmacy.

With the Costco Home Delivery Pharmacy

- You get up to a 90-day supply delivered directly to you — with free standard shipping.
- You can easily order refills online, over the phone or by mail.
- Multiple safety and advanced quality checks are in place to make sure you get the right medication.

Please contact Costco Home Delivery Pharmacy at pharmacy.costco.com. You may also call 800-607-6861 for home delivery forms and instructions. Please note that some pharmacies may not be in your plan. Log into the member home page at navitus.com to find pharmacies that are in your plan or call 866-333-2757.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

Formulary

A formulary is a list of drugs (both generic and brand name) that are preferred by the health plans. You can learn more about your plan's prescription drug coverage, including what drugs are on the formulary, by contacting Navitus.

Note: Formularies are updated regularly. Please contact Navitus to obtain updates. It's good to keep checking back to determine if your prescriptions are a part of the formulary.

A note about the High-Deductible Health Plans: If you enroll in a High-Deductible Health Plan, you will pay the full cost of your prescription drugs until you meet your deductible. However, if you use a participating pharmacy, you will receive a discounted price for prescription drugs. After you meet the deductible, prescriptions are provided at no cost to you.

Prescription Drugs
Retirees 65 & Older

Retirees Over 65 have the option to choose between two prescription drug plans.

Option 1: Navitus – Non-Medicare Part D
Prescription benefits can be found on pages 11 & 12 and rates can be found on page 19. This prescription plan is the same plan as if you were an active employee and is not a Medicare Part D Plan, however, coverage is creditable. Please review the separate Health Plan Notices on page 37 for more detailed information.

Option 2: Navitus Medicare® (PDP) – Medicare Part D (EGWP)
The City of Chico offers a prescription drug plan (PDP) option through the Medicare Part D program called Navitus Medicare® (PDP). This drug plan is comparable to the other prescription plan and offers better coverage than a standard Medicare Part D plan. Some added benefits to this plan include lower premiums and reduced out of pocket costs.

The PDP plan is a Medicare Part D Plan and the Formulary listing may be different than the other prescription plan. The City is allowing retirees to choose between the plans based upon the one that best fits your needs. There is a premium rate difference between the two plans. Please review the rates on page 19 prior to making your selection.

You are not permitted to be enrolled in two Medicare Part D plans, therefore, if you are enrolled in another Medicare Part D program outside of the City, you will need to choose only one. There is more detailed information on pages 11 and 12 on this Prescription plan that will assist in your evaluation of the program. Rates for these plan options can be found on page 19.

Medicare PDP Plan

Copays	$5 / $20 / $50 Rx Plan
Navitus Pharmacy Network	Yes
Formulary	Navitus Medicare (PDP) Formulary
Cost Share Assistance	Available for those who qualify for low-income subsidy
Copays (31-day retail supply)	$5 Generic / $20 Brand Name/ $50 Non-Formulary
Rx Out of Pocket Maximum	$2,100
Rx Deductible	None
Mandatory Generic	No Penalty
Retail Refill Allowance	No allowance; Member can fill up to 90 days at retail

Navitus Medicare® (PDP) – Medicare Part D (EGWP)

Are you eligible for Navitus Medicare PDP Plan?

To be eligible to enroll in this plan you must meet the following criteria:

- Entitled to Medicare Part A and/or be enrolled in Part B
  - Be at least 65 years old, or on long-term disability or have end-stage renal disease
- A retiree (or spouse) of the plan sponsor
- A permanent resident of the United States
- Can't be enrolled in any other Medicare Part D Prescription plan

How the Prescription plan works

The table below provides a summary of your benefit, including final cost-sharing information when filling prescriptions at a retail pharmacy or mail order. This plan provides coverage across all stages of your benefit (Initial Coverage and Catastrophic Coverage).

Initial Coverage Stage – for 2026
Applies. Members begin in this stage immediately and stay until they reach $2,100 in out-of-pocket costs.

Catastrophic Coverage Stage – for 2026
If you reach the Catastrophic Coverage state, you pay nothing for covered Part D drugs.

You may have cost sharing for excluded drugs that may be covered under our enhanced benefit, if our plan covers additional drugs not normally covered by Medicare Part D.

Cost Share Copays

	Retail 31-Day Supply	Retail 60-Day Supply	Retail 90-Day Supply	Home Delivery Mail Order 90-Day Supply
Generic Drug (Tier 1)	$5.00	$10.00	$15.00	$10.00
Preferred Brand Drug (Tier 2)	$20.00	$40.00	$60.00	$40.00
Non-Preferred Brand Drug (Tier 3)	$50.00	$100.00	$150.00	$100.00

EGWP- Navitus Medicare (PDP)

WHAT IS EGWP?

EGWP is a Medicare Part D prescription drug plan (PDP) that provides the standard Medicare Part D prescription drug coverage only to the Medicare-eligible retirees and dependents of the sponsoring employer group. This is a prescription drug plan with a Medicare contract. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. **You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan.**

EGWP Pre-Enrollment Notification Requirements

New or aging in Medicare-eligible employees and dependents will receive advance notice of intended group enrollment into the Navitus Medicare plan (EGWP). The communications include:

1. **EGWP pre-notification letter** - provides the effective date, opt out, contacts and penalty information
2. **EGWP Enrollment form** – a form must be completed by each individual person enrolling in EGWP. This includes eligible spouses and children enrolled in Medicare. The form and a copy of the Medicare ID card MUST be returned back to the City to retain for a minimum 11 years.
3. **EGWP Summary** – Benefit overview of the Medicare pharmacy benefits. This is updated each year.
4. **EGWP disclosure** – Medicare pharmacy disclosure form.

These communications will be sent at a minimum of 30 calendar days prior to subscriber's effective date in the plan.

Enrollment Requirements

You can only be in one Medicare prescription drug plan at a time. If you are currently enrolled in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage or an individual Medicare Advantage Plan, your enrollment in Navitus Medicare will end that coverage.

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform the City of any address changes.

Generally, Medicare limits when you can make changes to your coverage. You can join a new Medicare prescription drug plan only during the Medicare Annual Enrollment Period (October 15 to December 7), unless you qualify for certain special circumstances. Your former employer may have an annual enrollment period that differs from the Medicare time frame.

If you leave this plan and don't get other creditable prescription drug coverage (coverage that is at least as good as Medicare's coverage) for 63 or more days, you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

If you decide not to participate in this coverage, you can contact Medicare at (800)-MEDICARE (800) 633-4227, 24 hours a day, 7 days a week, for assistance with selecting another Part D plan. TTY users should call (877) 486-2048.

Plan Rules and Limitations

Navitus Medicare has formed a network of pharmacies. You may get your drugs at network retail pharmacies or a network home delivery pharmacy. Network pharmacies must generally be used except in cases of an emergency.

As a Medicare beneficiary, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. For more information about these processes, call Navitus Medicare Customer Service at the number on the back of your member ID card or review the *Evidence of Coverage*. A copy of the *Evidence of Coverage* is located at navitus.com or you may call Customer Service to request a copy.

How will my coverage work?

As of your effective date, you should begin using Navitus Medicare network pharmacies to fill your prescriptions. Please present the member ID card included with this mailing to your pharmacist. If you use an out-of-network pharmacy (except in an emergency), Navitus Medicare may not pay for your prescriptions. For more information or to find retail network pharmacies in your area, visit navitus.com or call General Customer Service at (866) 333-2757.

Out-of-Network Coverage

You must use Navitus Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact Navitus Medicare Customer Service at (866) 270-3877.

Does my plan cover Medicare Part B or non–Part D drugs?

In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non–Part D medications that are not normally covered by a Medicare prescription drug plan. The amount paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Customer Service at (866) 270-3877 for additional information about specific drug coverage and your cost-sharing amount.

Will my income affect my cost for Medicare Part D coverage?

Some people may pay an extra amount called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) because of their yearly income. If you have to pay an extra amount, Social Security – not your Medicare plan – will send a letter telling you what the extra amount will be and how to pay it. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.

Health Savings Account (HSA)
Retirees Under 65 & COBRA

IMPORTANT: You must be enrolled in the Anthem High-Deductible Health Plan (HDHP) to be eligible for an HSA.

A Health Savings Account (HSA) is a powerful tool for managing healthcare costs and saving for the future. This program is administered thru BCC**.**

How an HSA Works

You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

2026 IRS Contribution Limits	**Individual**: $4,400 per year **Family**: $8,750 per year **Are you age 55 or over?** You can contribute an additional $1,000 per year

You are ELIGIBLE for an HSA if:

- You are currently enrolled in Anthem HDHP and you are not enrolled in any another non-HDHP medical plan.
- You are not enrolled in a Healthcare FSA under your spouse's benefit plan. (Limited Purpose FSAs, which cover dental and vision expenses only, are allowed.)

You are NOT ELIGIBLE for an HSA if:

- You are enrolled as a dependent under another HDHP plan (e.g., through a spouse's plan).
- You are enrolled in Medicare, Medicaid or Tricare, or if you are someone else's tax dependent.

What about using your HSA for your dependents?
You can cover adult children under a health plan until age 26. However, you can only use funds from your HSA to pay for their expenses if they are a legal tax dependent.

Unlock the Power of Your HSA

Tax Advantages
Contributions, growth and eligible withdrawals are all tax-free.*

Retirement Savings
You can use HSA funds for healthcare expenses in retirement.**

Flexibility
Use funds for a wide range of qualified healthcare expenses.

Portability
Keep your HSA even if you change jobs or health plans.

*California & New Jersey tax HSA contributions and interest.
**For more information regarding HSAs, Retirement and Medicare, please contact your tax advisor for advice.

Find out more

- Eligible Expenses
- Ineligible Expenses

Health Premium
Retirees

RETIREES NO Medicare / WITH Medicare

Medical Rates (PRISM/Anthem Blue Cross)

	EARLY RETIREES (Under Age 65)				RETIREES OVER AGE 65 WITHOUT MEDICARE				RETIREES OVER AGE 65 W/MEDICARE A & B w/o PDP			RETIREES OVER AGE 65 W/MEDICARE A & B with PDP (EGWP)		
	EPO	90/10	80/20	HDHP	EPO	90/10	80/20	HDHP	EPO	90/10	80/20	EPO	90/10	80/20
Employee Only	1,298.00	1,298.00	1,196.00	843.00	1,948.00	1,946.00	1,794.00	1,267.00	880.00	879.00	810.00	791.00	793.00	732.00
Employee +1	2,763.00	2,757.00	2,546.00	1,794.00	4,142.00	4,138.00	3,818.00	2,692.00	1,871.00	1,870.00	1,723.00	1,581.00	1,586.00	1,463.00
Employee +2 or more	3,555.00	3,552.00	3,281.00	2,314.00	5,335.00	5,328.00	4,920.00	3,470.00	2,408.00	2,406.00	2,221.00	2,371.00	2,377.00	2,196.00
Dental Rates (Delta Dental PPO Basic)														
Employee Only	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70	31.70
Employee +1	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80	59.80
Employee +2 or more	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90	102.90
Dental Rates (Delta Dental PPO Buy-Up)														
Employee Only	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90	43.90
Employee +1	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70	83.70
Employee +2 or more	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20	146.20
Vision Rates (VSP)														
Employee Only	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47
Employee +1	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13
Employee +2 or more	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71

RETIREES With Medicare - Mixed Rates

Medical Rates (PRISM/Anthem Blue Cross)

	RETIREES MIXED MEDICARE w/o PDP			RETIREES MIXED MEDICARE (EGWP) with PDP		
	EPO	90/10	80/20	EPO	90/10	80/20
Employee +1 (1 w/Medicare / 1 w/out Medicare)	2,178.00	2,177.00	2,006.00	2,089.00	2,091.00	1,928.00
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	2,970.00	2,972.00	2,741.00	2,881.00	2,886.00	2,663.00
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	2,663.00	2,665.00	2,458.00	2,373.00	2,381.00	2,198.00
Dental Rates (Delta Dental PPO Basic)						
Employee +1 (1 w/Medicare / 1 w/out Medicare)	59.80	59.80	59.80	59.80	59.80	59.80
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	102.90	102.90	102.90	102.90	102.90	102.90
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	102.90	102.90	102.90	102.90	102.90	102.90
Dental Rates (Delta Dental PPO Buy-Up)						
Employee +1 (1 w/Medicare / 1 w/out Medicare)	83.70	83.70	83.70	83.70	83.70	83.70
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	146.20	146.20	146.20	146.20	146.20	146.20
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	146.20	146.20	146.20	146.20	146.20	146.20
Vision Rates (VSP)						
Employee +1 (1 w/Medicare / 1 w/out Medicare)	10.13	10.13	10.13	10.13	10.13	10.13
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	15.71	15.71	15.71	15.71	15.71	15.71
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	15.71	15.71	15.71	15.71	15.71	15.71

Employee Assistance Program Rate: If you elected the EAP at retirement, the monthly premium is $3.78. This rate includes coverage for ALL household members.

Health Premiums
COBRA

COBRA*				
Medical Rates (PRISM/Anthem Blue Cross)				
	COBRA			
	EPO	90/10	80/20	HDHP
Employee Only	941.46	941.46	870.06	609.96
Employee +1	2,005.32	2,003.28	1,846.20	1,301.52
Employee +2 or more	2,579.58	2,578.56	2,377.62	1,679.94
Dental Rates (Delta Dental)				
Employee Only	32.33	32.33	32.33	32.33
Employee +1	61.00	61.00	61.00	61.00
Employee +2 or more	104.96	104.96	104.96	104.96
Dental Rates (Delta Dental - Buy-Up PPO)				
Employee Only	44.78	44.78	44.78	44.78
Employee +1	85.88	85.88	85.88	85.88
Employee +2 or more	149.12	149.12	149.12	149.12
Vision Rates (VSP)				
Employee Only	5.58	5.58	5.58	5.58
Employee +1	10.33	10.33	10.33	10.33
Employee +2 or more	16.02	16.02	16.02	16.02

*Rates include 2% administration fee.

Employee Assistance Program Rate: As a COBRA Beneficiary, you may also elect the Employee Assistance Program as a benefit for $3.86 (includes a 2% administration fee) per month. This rate includes coverage for ALL household members.

Anthem Total Health Connections

NEW FOR 2026!

Helping you and your family feel confident & protected

Employees enrolled in an Anthem medical plan will be enrolled in Total Health Connections which provides you and your family with a dedicated Family Advocate — a personal health champion who offers proactive, compassionate, and no-cost support for everyday and emergency health needs. They can help you:

- Find and schedule care with top doctors and facilities in your plan
- Manage preventive care and chronic conditions
- Understand and use your health plan benefits
- Get quick preapprovals for urgent treatments
- Access in-house clinical experts who collaborate with your doctor to create a personal care plan

Focus on your whole health

Whole health also includes your mental health, along with social and community needs. Your dedicated Family Advocate can also connect you with community resources to help with food, childcare, transportation, and other social, financial, or mental health concerns.

A connected health record

You and your Family Advocate, doctors, and pharmacist all have access to the most up-to-date information on your health in a single record. These real-time insights can help improve your care and may lower your healthcare costs over time.

Sydney℠ Health App

Chat with your Family Advocate on our Sydney℠ Health mobile app. The Sydney℠ Health app also gives you a quick way to:

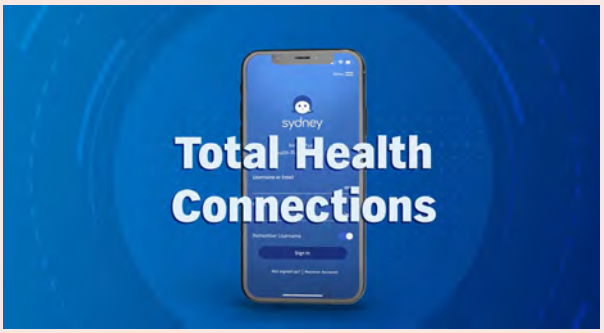
- Use your digital ID card
- Track your health goals and activities
- Check costs and view health plan details
- Access virtual care through video visits or chat

Get Started Today

Download or log in to the Sydney℠ Health mobile app or visit sydneyhealth.com to get started.

Watch the video to learn more about how to get connected with your Family Advocate and access the resources available via the Sydney℠ Health app.

Click to play video



PRISM Anthem Resources

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Lark Diabetes Management Program

Available to the members of the Anthem medical plans at no cost. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

Virtual Primary Care

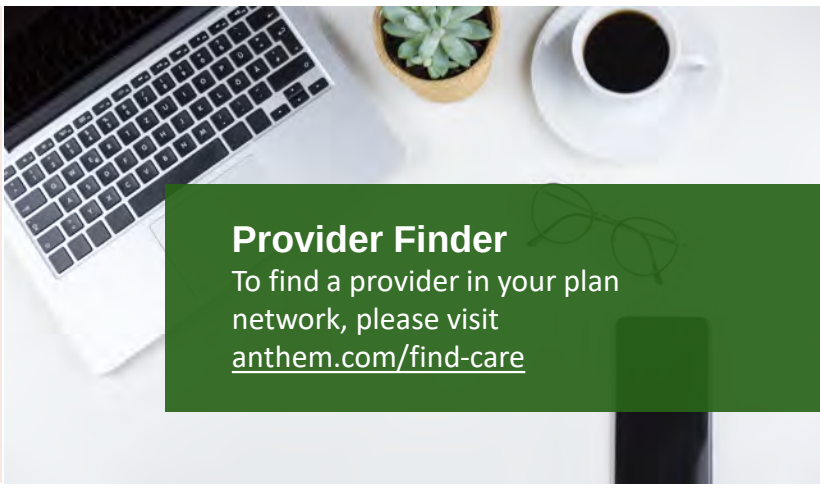
Through Anthem's LiveHealth Online Virtual Primary Care, members can choose from board-certified, in-network PCPs, and have that same doctor take care of them overtime for treatments including chronic conditions, preventative care, and acute care, at no extra cost to the member.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call the number on the back of your ID card.

Anthem ID Cards

Normally, one ID card will be issued to the subscriber and one to the spouse. For a subscriber with children, two cards will be issued, both showing the subscriber's name. If needed, ID cards showing the dependent child's name can be requested by calling the Member Services on the back of your ID card. Separately, all medical plan enrollees will receive a Navitus ID card to access pharmacy benefits.



Provider Finder

To find a provider in your plan network, please visit anthem.com/find-care

PRISM Value Added Services

Take advantage of these value-added services available to PRISM plan members to help you get and stay healthy.

Benefit Highlights	How To Get Started
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Available for preventative, acute, and chronic needs at no cost.	**Call:** (855) 902-2777 **Visit** hingehealth.com/prism
Hip, Knee & Spine Surgical Benefit, Oncology Treatment Benefit & Bariatric Procedures **Carrum Health** Access top-quality surgeons for hip and knee replacements, spinal fusion, and bariatric weight-loss procedures, with all medical costs and travel expenses for both the patient and a companion fully covered. An oncology benefit is also available, offering expert guidance and treatment options for all cancers, including breast cancer.	**Visit** carrumhealth.com
Diabetes, Obesity & Gastrointestinal Support **Digbi Health** Access personalized digital care programs that utilize genetic & gut microbiome analysis to address obesity, diabetes, digestive disorders and related conditions. Services include at-home DNA & gut biome testing, continuous glucose monitoring, personalized nutrition & lifestyle recommendations, access to health coaches, plus medically managed weight loss programs and support for GLP-1 medications for weight management.	**Call:** (866) 344-2189 **Visit** digbihealth.com
Free Generic Maintenance Medications **Rx 'N Go** As part of your benefits, you have the option to receive up to a 90-day supply of generic maintenance medication by mail at no cost to you ($0 copay, $0 shipping) through a convenient program called Rx 'n Go. For a list of eligible medications, call or visit their website.	**Call:** (888) 697-9646 **Visit** rxngo.com
Discount Medications **GoodRx** Discounts on medications for non-benefit eligible employees. GoodRx allows you to simply and easily search for retail pharmacies that offer the lowest price for specific medications.	**Members Call:** (888) 799-2553 **Pharmacies Call:** (844) 857-4351 **Visit** gold.goodrx.com

NEW! Digbi Health - Diabetes, Obesity & GI Care

Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Anthem through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

GLP-1 Eligibility

Eligibility requirements for accessing GLP-1s for weight management:

- 18 years or older and enrolled in Anthem (Mandatory).
- BMI 40 or higher without any comorbidity (OR)
- BMI 35 - 39 with at least one related comorbidity (OR)
- Mandatory: If you're on a GLP-1 for weight management, you should have lost 5% weight within 90 days of starting them.
- Digbi to be the sole prescriber for GLP-1s.

Get Started

1. Check your eligibility and sign up for the program at digbihealth.com/prism.
2. If you are eligible, download mobile app - onelink.to/digbi.
3. On the app, please confirm shipping address and answer onboarding questions - your kits will be ordered to your address, automatically.
4. Starting January 1, 2026, you will have 90 days to go through Digbi Health's Reauthorization for weight management GLP-1 medication based on the new eligibility criteria.

Digbi Health App

- **Get at-home Test Kits -** Within a week, you'll receive a comprehensive testing kit including a Genetic Test, a Gut Microbiome Test, and an Abbott Libre Continuous Glucose Monitor. Please follow instructions to collect samples and return kits using pre-labeled shipping.
- **Sync your Health Apps -** Connect Apple or Google Health Apps with the Digbi App. Navigate to settings, choose "Health", then connect by tapping "Refresh" under "Apple Health".
- **Say hi to your Coach! -** Tap the 'Coach' button at the bottom to start engaging with your health coach on the app and upload meal pictures for scoring while you await test results.

Dental

We offer dental coverage through Delta Dental. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

City of Chico offers a choice of both a basic PPO dental plan and a buy-up plan thru Delta Dental. The Delta Dental PPO give you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. Their network is made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage and benefit from discounted rates. This guide serves as a summary of the dental plan. We encourage you to review plan documents before enrolling in coverage.

Dental insurance covers multiple types of treatment:

1. **Preventive** care includes exams, cleanings and x-rays
2. **Basic** care focuses on repair & restoration with services such as fillings, simple tooth extractions & sealants. Endodontics (root canal), periodontics (gum treatment) & oral surgery also fall under **Basic** care.
3. **Major** care goes further than basic and includes crowns, inlays, onlays and cast restorations. Prosthodontics (bridges, dentures & implants) also fall under **Major** care.
4. **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental PPO – Basic Plan

Key Features	Delta Dental PPO Dentists**	Non-Delta Dental PPO Dentists**
Calendar Year Deductible	Single: $15 Family: $45	Single: $25 Family: $75
Calendar Year Maximum Benefits	$1,000	
Diagnostic & Preventive (D&P) *(exams, cleanings & x-rays)*	100%	80%
Basic Services *(fillings, simple tooth extractions & sealants)*	80%	80%
Endodontics *(root canals)*	80%	80%
Periodontics *(gum treatment)*	80%	80%
Oral Surgery	80%	80%
Major Services *(crowns, inlays/onlays & cast restorations)*	80%	80%
Prosthodontics *(bridges, dentures & implants)*	50%	50%
Orthodontia *(adults & children)*	50%	50%
Orthodontia Maximum	$500 per calendar year	
Waiting Period	None	

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

In-Network Delta Dental PPO Dentist	Out-of-Network Delta Dental Premier Dentists & Non-Delta Dental Dentists
You will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist.	You are responsible for the difference between the amount Delta Dental pays and the amount your non-Delta Dental dentist bills. You will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist.
PPO dentists agree to accept a reduced fee for PPO patients.	Delta Premier dentists may not balance bill above Delta Dental's approved amount, so your out-of-pocket costs may be lower than with non-Delta Dental dentists' charges.
You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the dentist.	Non-Delta Dental dentists may require you to pay the entire amount of the bill in advance and wait for reimbursement. Delta Premier dentists charge you only the patient's share at the time of treatment.
PPO dentists will complete claim forms and submit them for you at no charge.	You may have to complete and submit your own claim forms or pay your non-Delta Dental dentist a service fee to submit them for you. Delta Premier dentists will complete claim forms and submit them for you at no charge.

NEW! Delta Dental PPO - Buy-Up Plan

Key Features	Delta Dental PPO Dentists**	Delta Dental Premier Dentists**	Non-Delta Dental Dentists**
Calendar Year Deductible *Single / Family*	$15 / $45	$15 / $45	$25 / $75
Calendar Year Maximum Benefits	$2,000 *D&P services do not count towards maximum*		
Diagnostic & Preventive (D&P) *(exams, cleanings & x-rays)*	100%	100%	100%
Basic Services *(fillings, simple tooth extractions & sealants)*	90%	90%	80%
Endodontics *(root canals)*	90%	90%	80%
Periodontics *(gum treatment)*	90%	90%	80%
Oral Surgery	90%	90%	80%
Major Services *(crowns, inlays/onlays & cast restorations)*	60%	60%	50%
Prosthodontics *(bridges, dentures & implants)*	60%	60%	50%
Orthodontia *(adults & children)*	50%	50%	50%
Orthodontia Maximum	$1,500 lifetime maximum		
Waiting Period	None		

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

PRISM Delta Dental Resources

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. Opt in by visiting deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Virtual Dentistry

Virtual Dentistry is a photo-based tele-dentistry app for PPO & premier plan members. Although Virtual Dentistry is not available for dental emergencies, members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist that is part of the PPO & Premier Network can highlight issues from the photos, such as cavities, gum disease, oral hygiene, or other dental concerns. The dentist can then assist with next steps or possible treatments or a home care regimen.

Cost Estimator

Members can plan visits and compare costs before receiving treatment. Estimates will be personalized based on your plan benefits, and you'll be able to compare procedure costs at nearby dentists.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. Members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

LifePerks

As a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life. Register and learn more about LifePerks at discountmember.lifecare.com.

Finding a Delta Provider

To find a Delta Dental provider near you, please visit deltadentalins.com and click "Find a Dentist".

Vision

We offer vision coverage through VSP. Vision coverage helps with the cost of eyeglasses or contacts.

Vision Plan Overview

The City of Chico offers vision coverage through VSP with an extensive network of optometrists and vision care specialists. The City pays 100% of the employee only premium; employees are responsible for any dependent premiums. Under this plan, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will receive a reduced level of benefits.

What you need to know	
Vision Plan *VSP Network*	• You can use a VSP provider or another provider of your choice • Out-of-network coverage will have higher costs • The plan will reimburse up to a specific dollar amount for most materials

VSP Vision Plan

The chart below provides a summary of covered services, frequencies and costs.

Services	Vision Service Plan	
	In-Network (VSP Choice)	Out-of-Network
Co-payments		
• Eye Exam	$10 copay	
• Primary Eye Care	$20 copay	
• Materials	$25 copay	
Frequency		
• Exam	Once every 12 months	
• Lenses	Once every 12 months	
• Frames	Once every 24 months	
• Contact Lenses	Once every 12 months	
Coverage		
• Eye Exam	Covered in full after copay	Up to $45
• Single Lens	Covered in full	Up to $30
• Bi-Focal Lenses	Covered in full	Up to $50
• Tri-Focal Lenses	Covered in full	Up to $65
• Lenticular Lenses	Covered in full	Up to $100
• Standard Progressive Lenses	Covered in full	Up to $50
• Frame Allowance	Up to $125	Up to $70
**Costco Frame Allowance	Up to $70	N/A
Contact Lenses		
• Medically Necessary	Covered in full	Up to $210
• Elective – Up to %60 copay (fitting & evaluation)	Up to $160	Up to $105

The above information is provided for illustrative purposes only. Refer to the applicable carrier material for exact description of plan benefits and conditions.

VSP Savings and Resources

Extra Savings on Glasses and Sunglasses

Get an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

TruHearing® Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Essential Medical Eye Care

With your vision benefits from VSP, you have access to supplemental coverage for urgent and medical eye care. Essential Medical Eye Care includes:

- Fully covered retinal screening for members with diabetes
- Exams and services to treat immediate issues like pink eye and sudden changes in vision
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more

If you need treatment, contact your VSP network doctor to schedule an appointment or visit vsp.com to find a doctor.

Access To Over $3,000 In Exclusive Member Savings

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Optum can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 6 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

Available resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact Optum EAP

Phone: (866) 248-4096

Website:
liveandworkwell.com
Access code: CHICO

Discount Benefit – Pet Insurance

Met Life Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. MetLife provides coverage for this program. You can enroll in this program at any time.

For a quote and to enroll in these benefits, visit www.metlife.com/getpetquote or call (800) GET-MET8.

MetLife | Pet Insurance

Plan Contacts

If you need to reach our plan providers, their contact information is shown below:

Plan Type	Provider	Phone Number	Website/Email	Policy No.
Medical	Anthem Blue Cross	(800) 967-3015	anthem.com/ca/ms/prism	EPO: 175075T401 90% PPO: 175075T411 80% PPO: 175075T405 HDHP: 175075T417
	Carrum Health	(888) 855-7806	carrumhealth.com	Registration Code: PRISM
	LiveHealth Online	(888) 548-3432	livehealthonline.com	-
	Digbi Health	(866) 344-2189	digbihealth.com	-
	Hinge Health	(855) 902-2777	hingehealth.com	Registration Code: PRISM
Pharmacy	Navitus	(866) 333-2757	Navitus.com	Chico
	Rx 'N Go	(888) 697-9646	Rxngo.com	-
Dental	Delta Dental	(800) 765-6003	deltadentalins.com	Retiree: 74-0002 COBRA: 74-0003
Vision	VSP	(800) 877-7195	vsp.com	12137687
Employee Assistance Program (EAP)	Optum Emotional Wellbeing Solutions	(866) 248-4096	liveandworkwell.com	CHICO
Pet Insurance	MetLife	(800) GET-MET8	metlife.com/getpetquote	AG626F4
Retiree & COBRA Billing	BCC	(800) 685-6100	benxcel.net	N/A

Glossary

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services. Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

Glossary

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Important Plan Information

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on this page.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Medicare Part D Notice

Important Notice from the City of Chico About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Chico 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 Chico has determined that the prescription drug coverage offered by the medical plans 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, City of Chico coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under Anthem is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Chico prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Chico and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. 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 Chico 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	10/1/2025
Name of Entity/Sender:	City of Chico
Contact-Position/Office:	Human Resources & Risk Management Office
Address:	411 Main Street, Chico, CA 95928
Phone Number:	(530) 879-7900

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, 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 section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Chico's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the City of Chico's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City of Chico's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2025**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
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

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
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: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565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