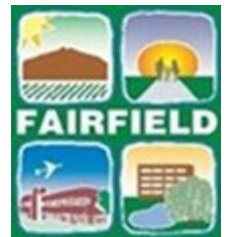


# 2026 BENEFITS (Retirees)



Ready, Set Enroll!



# CONTENTS



## MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to the Important Plan Information section for additional details.

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# GETTING STARTED

## 2026 BENEFITS

January 1, 2026  
through  
December 31, 2026

### IMPORTANT NOTE:

This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

The City of Fairfield values the contributions you have made to our success and wants to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We are committed to providing you with the resources you need to understand your options and how your choices may impact your financial situation.

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

# WHO'S ELIGIBLE FOR BENEFITS?



## DROPPING COVERAGE

Dropping coverage in any one or all of the City's retiree medical, dental, or vision plans at retirement is irrevocable. What this means is that if you drop any existing coverage at retirement, or at any time later, you will not be eligible for reinstatement onto that plan at a future date.

## Employees

If you or a covered dependent will turn age 65 during this plan year, it is your responsibility to enroll in Medicare Parts A/B. If you are interested in enrolling in the Kaiser Senior Advantage Plan, please contact Human Resources at least two to three months before your 65th birthday for enrollment information. Adhering to Medicare's strict deadlines will avoid any potential delay in enrollment, which could impact your Senior Advantage premiums.

## Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted, stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

## Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

# P&A Group

The City of Fairfield has selected P&A Group to manage its billing services and support retirees during open enrollment. Invoices will be mailed to you on the 15th of each month, with a due date of the first of the following month and a 30-day grace period. For example, an invoice due November 1st will be sent to you on October 15th, and you have the entire month of November to make payment. As long as your payment is made electronically or postmarked by the last calendar day of that month, your coverage will remain in effect. Late payment letters are also sent as a courtesy to remind you that payment is due.

## Payments – P&A offers multiple payment options:

- Secure Online Payment – To make a one-time payment or set up recurring monthly payments, create an account on our website [www.padmin.com](http://www.padmin.com)
- IVR (Integrated Voice Response) – To make a one-time payment or set up recurring monthly payments; call P&A at (800) 688-2611 to make a payment over the phone.
- ACH Payment – To set up an automatic debit from your checking or savings account, please complete the enclosed ACH authorization form and return it to the P&A Group. With this option, you will need to make a payment by check for the first of the month while this process is set up. You can also authorize this process online by logging into your account at [www.padmin.com](http://www.padmin.com)
- Check or Money Order – Pay by check or money order and mail your payments to: P&A Group, Dept. 652, PO Box 8000, Buffalo, NY 14267-8000.

## P&A Website

- P&A offers several ways to manage your benefits online. Please visit [www.padmin.com](http://www.padmin.com) to set up your account. Within the “My Benefits” page, you can view your insurance coverage, cancel coverage online, and make payments. Additionally, you can update your demographic information and view your invoice and payment history.

## Customer Service

- P&A Group customer service representatives are well-trained in administration and are here to help answer your questions. Representatives are available Monday through Friday from 8 am to 10 pm EST at (800) 688-2611 or email [cobra@padmin.com](mailto:cobra@padmin.com). Live chat is available during the same hours on our website, [www.padmin.com](http://www.padmin.com), by clicking the “Online Chat” tab at the top of the page or through the “Contact Us” tab.



# MEDICAL

## OUR PLANS

### Kaiser Permanente

- HMO \$15 Early Retirees (under 65)
- HMO \$35 Early Retirees (under 65)
- Virtual Complete \$30 HMO Early Retirees (under 65)
- Senior Advantage HMO \$15
- Senior Advantage HMO \$25

### Sutter Health Plus

- HMO \$10 Early Retirees (under 65)
- HMO \$20 Early Retirees (under 65)
- DHMO Early Retirees (under 65)

### Western Health Advantage

- HMO \$15 Early Retirees (under 65)
- HMO \$40 Early Retirees (under 65)
- DHMO Early Retirees (under 65)

### The Hartford

- Medicare Supplemental Plan

We offer 5 medical plans through Kaiser Permanente, 3 medical plans through Sutter Health Plus, 3 medical plans through Western Health Advantage and the Medicare supplemental plan through The Hartford.

## Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

### Do you prefer specific doctors or hospitals?

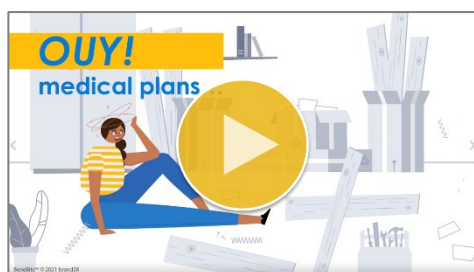
If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network.

### What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

### Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total healthcare cost.



# Kaiser Medical Plans – Early Retirees (Under 65)

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Kaiser HMO \$15	Kaiser HMO \$35	Kaiser Virtual Complete \$30
	In-Network	In-Network	In-Network
<b>Plan Year Deductible<sup>1</sup></b> Individual/Family Embedded/Aggregate <sup>2</sup>	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$2,000 / \$4,000 Embedded
<b>Plan Year Out-of-Pocket Maximum<sup>1,4</sup></b> Individual /Family Embedded/Aggregate <sup>3</sup>	\$1,500 / \$3,000 Embedded	\$1,500 / \$3,000 Embedded	\$5,000 / \$10,000 Embedded
<b>Office Visit</b> Primary Care Specialist	\$15 copay \$15 copay	\$35 copay \$35 copay	\$30 copay <sup>5,6</sup> \$30 copay <sup>5</sup>
<b>Online Visit</b>	No charge	No charge	No charge
<b>Preventive Services</b>	No charge	No charge	No charge
<b>Chiropractic</b> (20 visits/year)	\$15 copay	\$15 copay	\$15 copay
<b>Lab</b> <b>X-Ray</b>	No charge No charge	No charge No charge	\$15 copay 20% <sup>5</sup>
<b>Urgent Care</b>	\$15 copay	\$35 copay	\$30 copay <sup>5,6</sup>
<b>Emergency Room</b>	\$50 copay (waived if admitted)	\$75 copay (waived if admitted)	20% <sup>5</sup> (waived if admitted)
<b>Inpatient Hospitalization</b>	No charge	\$100 copay	20% <sup>5</sup>
<b>Outpatient Surgery</b>	\$15 copay	\$35 copay	20% <sup>5</sup>
<b>PRESCRIPTION DRUGS - Kaiser Permanente Pharmacy</b>			
<b>Plan Year Deductible</b>	N/A	N/A	N/A
<b>Plan Year Out-of-Pocket Maximum</b>	Combined with medical	Combined with medical	Combined with medical
<b>Retail- 30 Day Supply</b> Generic Preferred Brand Non-preferred Brand Specialty	\$5 copay (100-days) \$15 copay (100-days) \$15 copay (approval needed) 20% up to \$150	\$10 copay \$30 copay \$30 copay (approval needed) \$50 copay	\$15 copay \$30 copay \$30 copay (approval needed) 20% up to \$250
<b>Mail Order- 100 Day Supply</b> Generic Preferred Brand Non-preferred Brand Specialty	\$5 copay \$15 copay \$15 copay (approval needed) Not covered	\$20 copay \$60 copay \$60 copay (approval needed) Not covered	\$30 copay \$60 copay \$60 copay (approval needed) Not covered

<sup>1</sup>Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

<sup>2</sup>An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

<sup>3</sup>An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

<sup>4</sup>All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

<sup>5</sup>After deductible.

<sup>6</sup>Plan deductible doesn't apply for your first 3 visits combined for primary care, urgent care, mental health, and substance use disorder treatment services as described in the EOC

# Kaiser Medical Plans – Senior Advantage

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Kaiser HMO Senior Advantage \$15	Kaiser HMO Senior Advantage \$25
	In-Network	In-Network
<b>Plan Year Deductible<sup>1</sup></b> Individual/Family Embedded/Aggregate <sup>2</sup>	\$0 / \$0 Embedded	\$0 / \$0 Embedded
<b>Plan Year Out-of-Pocket Maximum<sup>1,4</sup></b> Individual /Family Embedded/Aggregate <sup>3</sup>	\$1,000 / \$2,000 Embedded	\$1,000 / \$2,000 Embedded
<b>Office Visit</b> Primary Care Specialist	\$15 copay \$15 copay	\$25 copay \$25 copay
<b>Online Visit</b>	No charge	No charge
<b>Preventive Services</b>	No charge	No charge
<b>Chiropractic</b> (20 visits/year)	\$15 copay	\$15 copay
<b>Lab</b> <b>X-Ray</b>	No charge No charge	No charge No charge
<b>Urgent Care</b>	\$15 copay	\$25 copay
<b>Emergency Room</b>	\$50 copay (waived if admitted)	\$50 copay (waived if admitted)
<b>Inpatient Hospitalization</b>	No charge	\$250 copay/admittance
<b>Outpatient Surgery</b>	\$15 copay/procedure	\$25 copay/procedure
<b>PRESCRIPTION DRUGS - Kaiser Permanente Pharmacy</b>		
<b>Plan Year Deductible</b>	N/A	N/A
<b>Plan Year Out-of-Pocket Maximum</b>	Combined with medical	Combined with medical
<b>Retail</b> Generic Preferred Brand Supply	\$5 copay \$15 copay 100 day	\$10-\$30 \$25-\$75 30 day - 100 day
<b>Mail Order</b> Generic Preferred Brand Supply	\$5 copay \$15 copay 100 day	\$10-\$20 \$25-\$50 30 day - 100 day

<sup>1</sup>Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

<sup>2</sup> An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

<sup>3</sup>An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

<sup>4</sup>All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

<sup>5</sup>After deductible.

# Sutter Health Plus Medical Plans – Early Retirees (Under 65)

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Sutter HMO \$10	Sutter HMO \$20	Sutter Deductible DHMO
	In-Network	In-Network	In-Network
<b>Plan Year Deductible<sup>1</sup></b> Individual/Family Embedded/Aggregate <sup>2</sup>	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$1,500 / \$3,000 Embedded
<b>Plan Year Out-of-Pocket Maximum<sup>1,4</sup></b> Individual/Family Embedded/Aggregate <sup>3</sup>	\$1,000 / \$2,000 Embedded	\$1,500 / \$3,000 Embedded	\$4,000 / \$8,000 Embedded
<b>Office Visit</b> Primary Care Specialist	\$10 copay \$20 copay	\$20 copay \$40 copay	\$20 copay \$40 copay
<b>Online Visit</b>	\$5 copay	\$10 copay	\$10 copay
<b>Preventive Services</b>	No charge	No charge	No charge
<b>Chiropractic</b> (20 visits/year)	\$10 copay	\$20 copay	\$20 copay
<b>Lab</b> <b>X-Ray</b> <b>Complex Imaging</b>	\$10 copay \$10 copay \$50 copay	\$10 copay \$10 copay \$50 copay	\$20 copay \$10 copay \$50 copay
<b>Urgent Care</b>	\$20 copay	\$40 copay	\$40 copay
<b>Emergency Room</b>	\$100 copay (waived if admitted)	\$200 copay (waived if admitted)	20% <sup>5</sup> (waived if admitted)
<b>Inpatient Hospitalization</b>	\$100/day (up to 5 days)	\$250/day (up to 5 days)	20% <sup>5</sup>
<b>Outpatient Surgery</b>	\$25 copay	\$50 copay	20% <sup>5</sup>
<b>PRESCRIPTION DRUGS - Shutter Health Plus</b>			
<b>Plan Year Deductible</b>	N/A	N/A	N/A
<b>Plan Year Out-of-Pocket Maximum</b>	Combined with medical	Combined with medical	Combined with medical
<b>Retail- 30 Day Supply</b> Generic Preferred Brand Non-preferred Brand Specialty	\$5 copay \$20 copay \$40 copay 10% up to \$250	\$10 copay \$30 copay \$75 copay 10% up to \$250	\$10 copay \$30 copay \$75 copay 10% up to \$250
<b>Mail Order- 100 Day Supply</b> Generic Preferred Brand Non-preferred Brand Specialty	\$10 copay \$40 copay \$80 copay Not covered	\$20 copay \$60 copay \$150 copay Not covered	\$20 copay \$60 copay \$150 copay Not covered

<sup>1</sup>Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

<sup>2</sup>An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

<sup>3</sup>An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

<sup>4</sup>All covered expenses, including your medical deductibles and prescription copays, accumulate towards the out-of-pocket maximum.

<sup>5</sup>After deductible.

# Western Health Advantage Medical Plans – Early Retirees (Under 65)

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Western HMO \$15	Western HMO \$40	Western DHMO 1000
	In-Network	In-Network	In-Network
<b>Plan Year Deductible<sup>1</sup></b> Individual/Family Embedded/Aggregate <sup>2</sup>	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$1,000 / \$2,000 Embedded
<b>Plan Year Out-of-Pocket Maximum<sup>1,4</sup></b> Individual/Family Embedded/Aggregate <sup>3</sup>	\$1,500 / \$3,000 Embedded	\$1,500 / \$3,000 Embedded	\$5,000 / \$10,000 Embedded
<b>Office Visit</b> Primary Care Specialist	\$15 copay \$15 copay	\$40 copay \$40 copay	\$20 copay \$20 copay
<b>Online Visit</b>	\$15 copay	\$40 copay	\$20 copay
<b>Preventive Services</b>	No charge	No charge	No charge
<b>Chiropractic</b> (20 visits/year)	\$15 copay	\$15 copay	\$15 copay
<b>Lab</b> <b>X-ray</b> <b>Complex Imaging</b>	No charge No charge No charge	No charge No charge No charge	No charge No charge No charge
<b>Urgent Care</b>	\$20 copay	\$50 copay	\$50 copay
<b>Emergency Room</b>	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	20% <sup>5</sup> (waived if admitted)
<b>Inpatient Hospitalization</b>	No charge	No charge	20% <sup>5</sup>
<b>Outpatient Surgery</b>	\$100 copay	\$100 copay	\$250 copay <sup>5</sup>
<b>PRESCRIPTION DRUGS - Western Health Advantage</b>			
<b>Plan Year Deductible</b>	N/A	N/A	Combined with medical
<b>Plan Year Out-of-Pocket Maximum</b>	Combined with medical	Combined with medical	Combined with medical
<b>Retail- 30 Day Supply</b> Generic Preferred Brand Non-preferred Brand Specialty	\$10 copay \$30 copay \$50 copay Only available via mail order	\$10 copay \$30 copay \$50 copay Only available via mail order	\$10 copay \$30 copay \$50 copay Only available via mail order
<b>Mail Order- 90 Day Supply</b> Generic Preferred Brand Non-preferred Brand Specialty	\$20 copay \$60 copay \$100 copay 20% up to \$100 (30-day supply)	\$20 copay \$60 copay \$100 copay 20% up to \$100 (30-day supply)	\$20 copay \$60 copay \$100 copay 20% up to \$100 (30-day supply)

<sup>1</sup>Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

<sup>2</sup>An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

<sup>3</sup>An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

<sup>4</sup>All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

<sup>5</sup>After deductible.

# The Hartford Medicare Supplement Plan

The coinsurance (%) shows what the plan pays after the deductible.

	Medicare Benefits	Medicare Supplement
<b>Hospital Confinement</b> Part A	Medicare pays all approved amounts, but Medicare Part A Deductible (First 60 days)	Plan pays the Medicare Part A Deductible (First 60 days)
<b>Skilled Nursing Facilities</b> Part A	Medicare pays all approved amounts (First 20 days)	N/A (First 20 days)
<b>Hospice Care</b> Part A	Medicare pays all costs, but is limited to costs for outpatient drug and inpatient respite care	Plan pays coinsurance charges for inpatient respite care, drugs, and biologicals approved by Medicare
<b>Blood Deductible</b> (Hospital Confinement and Out-Patient Medical Expenses) Part A	None (First 3 pints) Medicare pays all additional amounts	Plan pays all costs (First 3 pints) N/A (Additional amounts)
<b>Out-Patient Medical Expenses</b> Part B	Plan pays Medicare Part B Deductible (Remainder: Medicare pays 80% & Plan pays 20%)	Plan pays Medicare Part B Deductible (Remainder: Medicare pays 80% & Plan pays 20%)
Medicare Part B Deductible	None	Plan pays Medicare Part B Deductible
Remainder of Medicare – approved amounts	Medicare pays generally 80%	Plan pays 20%
Clinical Laboratory services, blood tests, urinalysis and more	Medicare pays all costs	N/A
<b>Additional Services</b> Preventive Medical Care & Cancer Screenings	Medicare pays all costs	Plan pays 100% of remaining covered expenses incurred not covered by Medicare
<b>Physical Exam</b> (within first 12 months)	Medicare pays all costs	N/A
<b>Annual Wellness Visit</b>	Medicare pays all costs	N/A
<b>Vaccinations</b>	Medicare pays all costs	N/A
<b>Breast Cancer Screening</b> Mammogram once per year	Medicare pays all costs	N/A
<b>Foreign Travel Emergency</b>	None	Plan pays 80% after \$250 Deductible (to a lifetime maximum of \$50,000)

# KAISER RESOURCES

## One Pass Select Affinity by Optum

Through One Pass Select Affinity from Optum, members can choose a fitness plan and gain unlimited access to all locations within that plan, as well as extensive digital resources.

Members can choose the plan that fits their needs, with competitive plans starting at \$10 per month. Members who sign up can also access the Optum Additional service, which includes healthy meal delivery and 20% discounts on chiropractors, acupuncturists, and massage therapists. Learn more at [healthy.kaiserpermanente.org/health-wellness/fitness-offerings](https://healthy.kaiserpermanente.org/health-wellness/fitness-offerings).

## 24/7 Care Advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (866) 454-8855 (NorCal).

## Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Visit [healthy.kaiserpermanente.org/get-care/traveling](https://healthy.kaiserpermanente.org/get-care/traveling) to learn about what to do if you need emergency or urgent care during your trip.

## Finding a Kaiser Provider

To find a Kaiser Permanente provider near you, please visit [kp.org](https://kp.org) or call (800) 464-4000.

## My Health Manager

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](https://healthy.kaiserpermanente.org) or downloading the Kaiser Permanente app from the App Store<sup>SM</sup> or Google Play<sup>®</sup>.

## Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. Adult members can get Calm at [kp.org/selfcareapps](https://kp.org/selfcareapps).

## Headspace Care App

The Headspace Care app offers immediate, one-on-one support for managing various common challenges — from stress and low mood to work and relationship issues, and more. Headspace Care’s highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Get started today at [kp.org/selfcareapps](https://kp.org/selfcareapps).



# KAISER RESOURCES, CONT.

## Online Wellness Tools

Visit [healthy.kaiserpermanente.org/health-wellness](https://healthy.kaiserpermanente.org/health-wellness) for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more – all at no cost.

## ClassPass

Kaiser members can access free on-demand video workouts at no cost and receive reduced rates for in-person fitness classes. To get started, visit [healthy.kaiserpermanente.org/health-wellness/fitness-offerings](https://healthy.kaiserpermanente.org/health-wellness/fitness-offerings).

## Health Classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at [healthy.kaiserpermanente.org/health-wellness/classes-programs](https://healthy.kaiserpermanente.org/health-wellness/classes-programs) – some may require a fee.

## Personal Wellness Coaching

Get help reaching your health goals. Work one-on-one with a wellness coach by phone at no cost. Find out more at [healthy.kaiserpermanente.org/health-wellness/wellness-coaching](https://healthy.kaiserpermanente.org/health-wellness/wellness-coaching) or call (866) 862-4295.



# SUTTER HEALTH PLAN RESOURCES

## Health and Wellness Site

Members have access to a range of tools and resources designed to help them achieve their health and wellness objectives. Resources include a Personal Health Assessment (PHA) that evaluates your health history and lifestyle to generate a personalized health risk report. After completing the PHA, access 13 Action Plan modules (e.g., Healthy Eating, Stress Management) and a comprehensive Health Library with tools like a Symptom Checker and Video Library. To get started, log in to [shplan.org/memberportal](https://shplan.org/memberportal) and select the Health and Wellness link in the Quick Access toolbar.

## Health Coaching Program

Members also have access to a complimentary Health Coaching Program for support with weight management, stress management, or quitting smoking. Coaching is private, phone-based, and tailored to your goals and values. The first call takes 20 minutes, and the follow-up is personalized.

## Doula Care Program

Sutter Health Plan members have access to Mahmee, an integrated care team that includes doulas, registered nurses, mental health coaches, and nutritionists — all at no additional cost. The program provides 12 months of comprehensive support tailored to your needs, whether preparing for delivery, managing your pregnancy, or navigating postpartum. Mahmee offers virtual visits, in-person care, and 24/7 support online and through the app. You can self-enroll by visiting [mahmee.com](https://mahmee.com), clicking on 'Check My Eligibility', and following the instructions. You can also call Mahmee at (818) 431-1118 or email [hello@mahmee.com](mailto:hello@mahmee.com).

## Mental Health Benefits

As a member, your coverage includes benefits for mental health and substance use disorder services through U.S. Behavioral Health Plan, California (USBHPC). You may self-refer for in-network office or virtual visits, and treatment is provided by psychiatrists and therapists who are part of USBHPC's behavioral health network. To find a participating behavioral health provider, call USBHPC at (855) 202-0984 or visit [liveandworkwell.com](https://liveandworkwell.com).

## Live and Work Well

USBHPC's website, [liveandworkwell.com](https://liveandworkwell.com), offers confidential, 24/7 access to a wide range of resources, including support for personal life, mental and physical health, addiction recovery, and crises. Users can explore educational content, find care providers for in-person or virtual appointments, and view benefits and claim information.

## Self Care by AbleTo

Access on-demand mental wellness support, self-care techniques, coping tools, meditations, and more. Completely confidential, AbleTo is available online and via mobile app at no extra cost as part of your behavioral health benefits through USBHPC, a subsidiary of Optum. For more information, visit [ableto.com/begin](https://ableto.com/begin).

## Ria Health

Ria Health is a confidential online alcohol treatment program that provides evidence-based care from the comfort of your home. It is available for members ages 18 years and older and offers medications, counseling, and support to help achieve lasting results. For more information or to self-refer, visit [riahealth.com/optum](https://riahealth.com/optum).

# WESTERN HEALTH ADVANTAGE RESOURCES

## Teladoc Virtual Urgent Care

Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Enroll with Teladoc online at [mywha.org/Teladoc](https://mywha.org/Teladoc) or by phone at 800-Teladoc (835-2362).

## Mental Health Services

Optum's Live and Work Well program offers a full spectrum of mental health and substance use disorder services without a referral from a primary care physician (PCP). Members have access to digital support tools and resources, customized treatment plans, and an extensive network of thousands of mental health providers (both virtual and in-person), to ensure prompt access to care and support. Visit [mywha.org/bh](https://mywha.org/bh) or call (800)765-6820 to access support and resources.

## High Blood Pressure Management

Through Livongo, Western Health Advantage members can receive an advanced blood pressure monitor, personalized insights, one-on-one coaching, and guidance on healthy habits. These tools and resources are available through an easy-to-use app and dashboard. Text "GO WESTERNHEALTHADV" to 85240 to learn more and join today. You can also visit [Ready.Livongo.com/WESTERNHEALTHADV/register](https://Ready.Livongo.com/WESTERNHEALTHADV/register) or call (800) 945-4355 and use registration code: **WESTERNHEALTHADV**.

## 24/7 Nurse Advice Line

The 24/7 Nurse Advice Line 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, receive allergy relief tips, or get advice on where to go for care. For help, call (888) 656-3574 (toll-free); hearing-impaired members may dial in by calling 711.

## Diabetes Management

Virta Health is a telehealth program that helps participants lower their blood sugar and A1C levels, reduce or eliminate diabetes medications, and lose weight. This program includes a medical coaching team, a weight scale, a glucose meter, ketone strips, lancets, swabs, and other essential resources to support you. Available to eligible participants with Type 2 Diabetes at no cost. Visit [virtahealth.com/join/wha](https://virtahealth.com/join/wha) to check your eligibility.

## Pain Management

Managing pain is easier through Kaia Health, an innovative program and app to help with back, neck, and knee pain. When you can't attend in-person therapy or travel to appointments, AI-driven technology utilizes your mobile phone to deliver coaching and feedback, functional assessment, and warm-ups for virtual therapy that is accessible anytime, anywhere. Visit [mywha.org/digitalcare](https://mywha.org/digitalcare) to learn more.



## Finding A WHA Provider

Go to [mywha.org/directory](https://mywha.org/directory) to search for the most updated in-network facilities, including urgent care centers, pharmacies, and clinic providers. Choose an urgent care center based on your PCP's medical group affiliation.

# WESTERN HEALTH ADVANTAGE RESOURCES, CONT.

## Personal Health Assessment

Personal Health Assessment program is an online health management tool where you complete an annual Personal Health Assessment (PHA). You will receive a health scorecard that connects you with resources and information to create an action plan and improve your health/score. It's a terrific proactive tool to further your health journey. Visit [mywha.org/wellness](https://mywha.org/wellness) to learn more.

## Nutrition Counseling

Whether dealing with issues of obesity, eating disorders, or needed weight gain, eligible members who meet specified medical criteria may talk to their doctor to get a referral to a nutritionist for visits. You'll have the same cost-sharing as for a primary care office visit. Visit [mywha.org/nutrition](https://mywha.org/nutrition) to learn more.

## Chronic Condition Management

Members living with a chronic illness have access to helpful resources and a care manager to assist them in managing their condition. Members living with the following chronic illnesses: asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), or diabetes (type 1 and type 2) may be eligible for personalized support to manage their health and related risk factors. Learn more at [mywha.org/dm](https://mywha.org/dm).

## Acupuncture and Chiropractic

Your back, neck, and joint pain are the primary reasons to seek care such as acupuncture or chiropractic care. WHA plans include Complementary and Alternative Care (CAM) through our partner, Landmark Healthplan of CA, and services do not require a referral. Visit [mywha.org/cam](https://mywha.org/cam) to learn more.

## Community Fit Classes

Join our popular virtual classes designed to boost confidence in body and mind. Led by a health and fitness coach, these creative exercises help develop strength and improve movement, allowing you to reduce stress and feel your best. Visit [mywha.org/communityfit](https://mywha.org/communityfit) to learn more.

## Fitness Center Partnerships

WHA provides you with opportunities to get active through our partnerships with local gyms and fitness centers. Active&Fit Direct™ offers you access to a wide range of fitness centers for a minimal monthly fee. We also offer discounts with local area fitness partners. Visit our website for a list of locations. Visit [mywha.org/fitness](https://mywha.org/fitness) to learn more.

## Health Classes and Support Groups

Access instructor-led health education programs sponsored by our network's medical groups. Find classes or support groups in nutrition, parenting, pregnancy and childbirth, and smoking cessation. Unless otherwise noted, most classes are free of charge. Visit [mywha.org/classes](https://mywha.org/classes) to learn more.

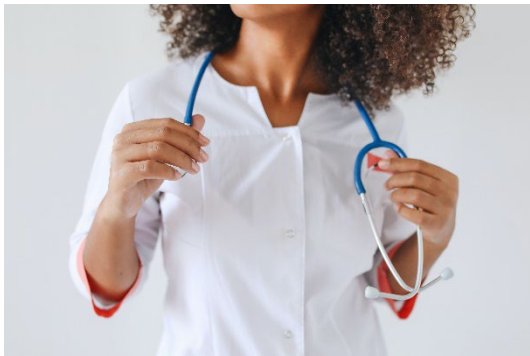
## Health and Fitness Discounts

Together with our Active&Fit™ partner, we bring ChooseHealthy® with savings on wellness products and services to help you discover new ways to live better every day. Get discounts of 10-50% on popular health and fitness brands. Save money on therapeutic massage services through a network of practitioners. Visit [mywha.org/discounts](https://mywha.org/discounts) to learn more.

## Online Healthy Recipe Library

Browse hundreds of healthy recipes from reputable health organizations supporting heart health and other health conditions. Reap the benefits of a nutritionally sound lifestyle, improving emotional well-being, weight management, and longevity. Visit [mywha.org/recipes](https://mywha.org/recipes) to learn more.

# PREVENTIVE CARE SCREENING BENEFITS



## TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

## You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

## What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit [healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/) for recommended guidelines.

**Preventive care is covered in full only when obtained from an IN-NETWORK provider.**

## Not all exams and tests are considered preventive






Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

# KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
<b>Nurseline</b> 	Quick answers from a trained nurse	<ul style="list-style-type: none"> <li>Identifying symptoms</li> <li>Decide if immediate care is needed</li> <li>Home treatment options and advice</li> </ul>	24/7	\$0
<b>Online visit</b> 	Many non-emergency health conditions	<ul style="list-style-type: none"> <li>Cold, flu, allergies</li> <li>Headache, migraine</li> <li>Skin conditions, rashes</li> <li>Minor injuries</li> <li>Mental health concerns</li> </ul>	24/7	\$
<b>Office visit</b> 	Routine medical care and overall health management	<ul style="list-style-type: none"> <li>Preventive care</li> <li>Illnesses, injuries</li> <li>Managing existing conditions</li> </ul>	Office Hours	\$\$
<b>Urgent care, walk-in clinic</b> 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> <li>Stitches</li> <li>Sprains</li> <li>Animal bites</li> <li>Ear-nose-throat infections</li> </ul>	Office Hours, or up to 24/7	\$\$\$
<b>Emergency room</b> 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> <li>Suspected heart attack or stroke</li> <li>Major bone breaks</li> <li>Excessive bleeding</li> <li>Severe pain</li> <li>Difficulty breathing</li> </ul>	24/7	\$\$\$\$\$

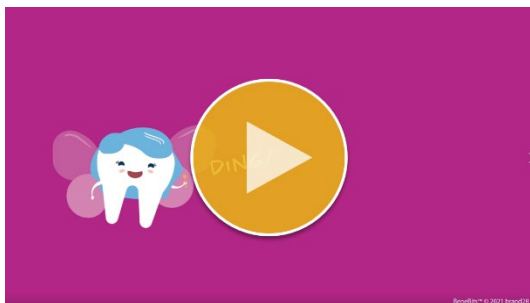


# DENTAL

## OUR PLANS

- Delta Dental Core PPO Plan
- Delta Dental Buy-up PPO Plan
- Delta Dental DeltaCare HMO Plan

*Click to play video*



We offer 3 dental plans through Delta Dental. The City of Fairfield provides you with comprehensive coverage through Delta Dental (CSAC EIA).

## Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

# Delta Dental Core Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Delta Dental Core DPPO Plan		
	In-Network	Premier Network	Out-of-Network
<b>Annual Deductible</b> Individual/Family	\$0 / \$0	\$25 / \$75	\$25 / \$75
<b>Annual Plan Maximum</b> Per Individual	\$1,500	\$1,500	\$1,000
<b>Waiting Period</b>	None	None	None
<b>Diagnostic &amp; Preventive</b>	No charge (deductible waived)	10% (deductible waived)	10% (deductible waived)
<b>Basic Services</b>			
Fluoride Treatment <sup>2</sup>	Included	Included	Included
Fillings	10%	20% <sup>1</sup>	20% <sup>1</sup>
Root Canals	10%	20% <sup>1</sup>	20% <sup>1</sup>
Periodontics	10%	20% <sup>1</sup>	20% <sup>1</sup>
<b>Major Services</b>	10%	20% <sup>1</sup>	20% <sup>1</sup>
<b>Prosthodontics</b>			
Dental Implants	40%	50% <sup>1</sup>	50% <sup>1</sup>
Bridges and Dentures			
<b>Orthodontia</b> Children only	50% (deductible waived)	50% (deductible waived)	50% (deductible waived)
<b>Ortho Lifetime Max</b>	\$1,500	\$1,500	\$1,500

<sup>1</sup>After deductible.

<sup>2</sup>Fluoride treatment for adults and children, limited to 2 treatments per year.

## What you need to know about this plan



### Features:

See any provider, but you'll pay more out of network

**Am I restricted to in-network providers?**

No

**Do I have to select a primary dentist?**

No

**Can I use my FSA?**

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

**Where can I get more details?**

For more information visit [deltadentalins.com](http://deltadentalins.com) or call 888-335-8227.

# Delta Dental Buy-up Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Delta Dental Buy-Up DPPO Plan		
	In-Network	Premier Network	Out-of-Network
<b>Annual Deductible</b> Individual/Family	\$0 / \$0	\$25 / \$75	\$25 / \$75
<b>Annual Plan Maximum</b> Per Individual	\$2,500	\$2,500	\$2,500
<b>Waiting Period</b>	None	None	None
<b>Diagnostic &amp; Preventive</b>	No charge (deductible waived)	10% (deductible waived)	10% (deductible waived)
<b>Basic Services</b>			
Fluoride Treatment <sup>2</sup>	Included	Included	Included
Fillings	10%	20% <sup>1</sup>	20% <sup>1</sup>
Root Canals	10%	20% <sup>1</sup>	20% <sup>1</sup>
Periodontics	10%	20% <sup>1</sup>	20% <sup>1</sup>
<b>Major Services</b>	10%	20% <sup>1</sup>	20% <sup>1</sup>
<b>Prosthetics</b>			
Dental Implants	40%	50% <sup>1</sup>	50% <sup>1</sup>
Bridges and Dentures			
<b>Orthodontia</b> Children only	50% (deductible waived)	50% <sup>1</sup> (deductible waived)	50% <sup>1</sup> (deductible waived)
<b>Ortho Lifetime Max</b>	\$1,500	\$1,500	\$1,500

<sup>1</sup>After deductible.

<sup>2</sup>Fluoride treatment for adults and children, limited to 2 treatments per year.

## What you need to know about this plan



### Features:

See any provider, but you'll pay more out of network

### Am I restricted to in-network providers?

No

### Do I have to select a primary dentist?

No

### Can I use my FSA?

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

### Where can I get more details?

For more information visit [deltadentalins.com](https://deltadentalins.com) or call 888-335-8227.

# Delta Dental DHMO Plan

You always pay the deductible and copayment (\$).

	Delta Dental DHMO Plan
	In-Network
<b>Annual Deductible</b> Individual/Family	\$0 / \$0
<b>Annual Plan Maximum</b>	None
<b>Waiting Period</b>	None
<b>Diagnostic &amp; Preventive<sup>1</sup></b>	\$0 - \$45 copay
<b>Basic Services<sup>1</sup></b> Fillings Root Canals Periodontics	\$0 - \$75 copay \$0 - \$205 copay \$0 - \$195 copay
<b>Major Services<sup>1</sup></b>	\$0 - \$195 copay
<b>Orthodontia<sup>1</sup></b> Adults (over age 19) Children (up to age 19)	\$1,900 copay \$1,700 copay
<b>Ortho Lifetime Max</b>	Unlimited

<sup>1</sup>Varies by services, see contract for fee schedule.

## What you need to know about this plan



### Features:

See any provider, but you'll pay more out of network

### Am I restricted to in-network providers?

Yes

### Do I have to select a primary dentist?

Yes

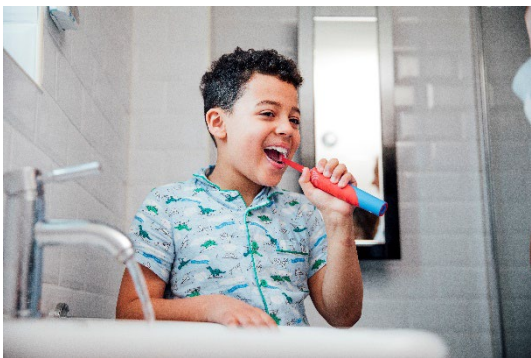
### Can I use my FSA?

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

### Where can I get more details?

For more information visit [deltadentalins.com](https://deltadentalins.com) or call 800-422-4234.

# DELTA DENTAL RESOURCES



## 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.

## 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. You can opt in by visiting [www.deltadentalins.com/smileway](http://www.deltadentalins.com/smileway) or by calling Customer Service Monday through Friday.

## Toothpic

Toothpic is a photo-based tele-dentistry app for PPO & premier plan members. Although Toothpic is not available for dental emergencies, members can schedule a virtual dental screening or submit photos for dental issues. A Delta Dental dentist, who is part of the PPO & Premier Network, can identify issues from the images, such as cavities, gum disease, oral hygiene concerns, or other dental concerns. The dentist can then assist with the next steps, possible treatments, or a home care regimen.

## Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized according to their benefits. Should members need to prepare in terms of costs, they can compare procedure costs at nearby dentists. Members can also receive a detailed explanation of their costs based on upcoming treatment.

## Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. For more information, call 1-888-779-1429 or email [amplifonusa.com@deltadentalins.com](mailto:amplifonusa.com@deltadentalins.com). PPO members may also be able to utilize their plan benefits in conjunction 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 they use an experienced QualSight LASIK surgeon. For more information, email [qualsight.com/-delta-dental](mailto:qualsight.com/-delta-dental) or call 1-855-248-2020.

## 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](http://discountmember.lifecare.com).



# VISION

## OUR PLANS

VSP Basic Plan

VSP Premier Plan

We offer 2 vision plans through VSP Vision.

### Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. However, even if you don't need vision correction, an annual eye exam checks the health of your eyes. It can also detect more serious health issues, such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

*Click to play video*



# VSP Vision Plans

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	Basic Plan		Premier Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Exams</b>				
Benefit	\$20 copay	Reimbursed up to \$45	\$10 copay	Reimbursed up to \$45
Materials	\$25 copay	See schedule below	\$25 copay	See schedule below
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
<b>Eyeglass Lenses</b>				
Single Vision Lens	\$25 copay	Reimbursed up to \$30	\$25 copay	Reimbursed up to \$30
Bifocal Lens	\$25 copay	Reimbursed up to \$50	\$25 copay	Reimbursed up to \$50
Trifocal Lens	\$25 copay	Reimbursed up to \$65	\$25 copay	Reimbursed up to \$65
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
<b>Frames</b>				
Benefit	\$150 + 20% discount over allowance	Reimbursed up to \$70	\$200 + 20% discount over allowance	Reimbursed up to \$70
Frequency	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months
<b>Contacts (Elective)<sup>1</sup></b>				
Conventional	\$130 allowance	Reimbursed up to \$105	\$200 allowance	Reimbursed up to \$105
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months

<sup>1</sup>Copay waived; instead of eyeglasses.

## What you need to know about this plan



**Features:**

See any provider, but you'll pay more out of network

**What other services are covered?**

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

**Eyeglasses are expensive. Will I still be able to afford them, even with insurance?**

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

**Where can I get more details?**

For more information visit [vsp.com/offers](https://vsp.com/offers) or call 800-877-7195.

# VSP SAVINGS AND RESOURCES



## ACCESS TO OVER \$3,000 IN EXCLUSIVE MEMBER SAVINGS

Visit [vsp.com/offers](https://www.vsp.com/offers) to learn more about these resources and other VSP exclusive member extras.

## Extra Savings on Glasses and Sunglasses

Get an extra \$20 to spend on featured frame brands. Go to [vsp.com/specialoffers](https://www.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.

Eyeconic<sup>®</sup>, an easy-to-use, in-network, online eyewear platform, is also available to all members. Eyeconic<sup>®</sup> offers free shipping and returns, a virtual try-on tool, free frame adjustments, contact lens consultations, and all-inclusive pricing on glasses and lenses. For more information on Eyeconic<sup>®</sup>, visit [eyeconic.com](https://www.eyeconic.com).

## Retinal Screening

You won't pay more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam.

## 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, you can use your frame allowance (if eligible) to purchase sunglasses from any VSP doctor.

## TruHearing<sup>®</sup> Hearing Aid Discount

VSP<sup>®</sup> 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](https://www.truhearing.com/vsp) or call (877) 396-7194.



## IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.
- Retiree frequently asked questions

# MONTHLY MEDICAL CONTRIBUTIONS EARLY RETIREES

Plans	2026 Premium Rates
Medical	
<b>Kaiser Permanente \$15 HMO</b>	
• Single	\$1,442.75
• Two Party	\$2,885.50
• Family	\$4,082.98
<b>Kaiser Permanente \$35 HMO</b>	
• Single	\$1,360.38
• Two Party	\$2,720.76
• Family	\$3,849.87
<b>Kaiser Permanente Virtual Complete</b>	
• Single	\$1,040.67
• Two Party	\$2,081.34
• Family	\$2,945.09
<b>SHP \$10 HMO</b>	
• Single	\$1,025.90
• Two Party	\$2,052.00
• Family	\$2,903.70
<b>SHP \$20 HMO</b>	
• Single	\$985.30
• Two Party	\$1,970.80
• Family	\$2,788.80
<b>SHP DHMO</b>	
• Single	\$813.10
• Two Party	\$1,626.30
• Family	\$2,301.30
<b>WHA \$15 HMO</b>	
• Single	\$1,190.92
• Two Party	\$2,381.84
• Family	\$3,373.72
<b>WHA \$40 HMO</b>	
• Single	\$1,080.86
• Two Party	\$2,161.72
• Family	\$3,061.92
<b>WHA DHMO</b>	
• Single	\$813.70
• Two Party	\$1,618.46
• Family	\$2,292.40

\*Retiree pays 100% of premium

# MONTHLY MEDICAL CONTRIBUTIONS – 65+ RETIREES

Plans	2026
Medical	Premium Rates
<b>Kaiser Permanente Senior Advantage \$15 HMO</b>	
• Subscriber w/Medicare	\$366.19
• Subscriber w/Medicare + Spouse w/o Medicare	\$1,808.94
• Subscriber w/Medicare + Spouse w/Medicare	\$732.38
• Subscriber w/Medicare + Spouse w/Medicare + Child(ren) Non-Medicare	\$1,929.86
• Medicare Part B Only	\$675.31
<b>Kaiser Permanente Senior Advantage \$25 HMO</b>	
• Subscriber w/Medicare	\$292.62
• Subscriber w/Medicare + Spouse w/o Medicare	\$1,653.00
• Subscriber w/Medicare + Spouse w/Medicare	\$585.24
• Subscriber w/Medicare + Spouse w/Medicare + Child(ren) Non-Medicare	\$1,714.35
• Medicare Part B Only	\$602.62
<b>The Hartford - Medicare Supplement Plan**</b>	
• Medical	\$348.13
• Rx	\$334.20

\*Retiree pays 100% of premium

\*\*All plans are now on a calendar year basis

# MONTHLY DENTAL CONTRIBUTIONS

Plans	2026 Premium Rates*
<b>Dental</b>	
<b>PPO Buy-Up 1 – PPO + Premier 1500</b>	
• Single	\$55.41
• Two Party	\$100.28
• Family	\$147.60
<b>PPO Buy-Up 2 – PPO + Premier 2500</b>	
• Single	\$62.66
• Two Party	\$113.84
• Family	\$167.69
<b>HMO – DeltaCare</b>	
• Single	\$20.10
• Two Party	\$35.80
• Family	\$52.80

# MONTHLY VISION CONTRIBUTIONS

Plans	2026 Premium Rates*
<b>Vision</b>	
<b>Base</b>	
• Single	\$6.03
• Two Party	\$12.06
• Family	\$14.35
<b>Premier</b>	
• Single	\$10.20
• Two Party	\$20.51
• Family	\$24.00

\*Retiree pays 100% of premium

# PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
Medical	Kaiser Permanente	(800) 464-4000	<a href="http://kp.org">kp.org</a>
Medical	Sutter Health Plan	(855) 315-5800	<a href="http://sutterhealthplus.org">sutterhealthplus.org</a>
Medical	Western Health Advantage	(888) 227-5942	<a href="http://westernhealth.com">westernhealth.com</a>
Medicare Supplement	The Hartford	(877) 480-2432	<a href="http://thehartford.com">thehartford.com</a>
Dental	Delta Dental	DPPO: (888) 335-8227 DHMO: (800) 422-4234	<a href="http://deltadentalins.com">deltadentalins.com</a>
Vision	VSP	(800) 877-7195	<a href="http://vsp.com">vsp.com</a>
HRA Administrator	P&A Group	(800) 688-2611	<a href="http://padmin.com">padmin.com</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 under age

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 at the end of this guide.

- **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.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Notice of Availability of Alternative Standard for Wellness Plans:** Describes right to alternatives ways of participating in employer's wellness program

## 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 Fairfield 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 Fairfield 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 Fairfield has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your City of Fairfield coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under health plan 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 Fairfield 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 Fairfield 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 Fairfield 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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.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:	January 1, 2026
Name of Entity/Sender:	The City of Fairfield
Contact-Position/Office:	Human Resources – <a href="mailto:benefits@fairfield.ca.gov">benefits@fairfield.ca.gov</a>
Address:	1000 Webster Street, Fairfield, CA
Phone Number:	(707) 428-7394

## 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 as those applicable to other medical and surgical benefits under this plan. For more information on WHCRA benefits, please contact 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 attending provider of the mother or newborn, 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 a provider to obtain authorization from the plan or the insurance issuer for prescribing a length of stay not exceeding 48 hours (or 96 hours). For more information on maternity benefits, please contact your plan administrator.

## HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Fairfield 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 Fairfield 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 on the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective on the first of the month following your enrollment request. In addition, you may enroll in the City of Fairfield health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days of gaining eligibility for medical plan coverage. If you request this change, coverage will be effective on the first of the month following your enrollment request. 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.

## ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible, you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee-only coverage under our base plan exceeds 9.96% in 2026 of your modified adjusted household income.

## Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the City of Fairfield, describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Human Resources Department.

## Notice of Choice of Providers

Your health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on selecting a primary care provider and a list of participating primary care providers, please contact your health plan directly. For children, you may designate a pediatrician as the primary care provider.

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

## Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards are available to all employees for participating in a wellness program. If you are unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Human Resources, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same rewards that is right for you, taking into account your health status.

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA and displays a currently valid OMB control number. Additionally, the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

# 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](http://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](http://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](http://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—

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

<b>GEORGIA – Medicaid</b>
GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>   Phone: 678-564-1162, press 2
<b>INDIANA – Medicaid</b>
Health Insurance Premium Payment Program All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>   <a href="http://www.in.gov/fssa/dfcr/">http://www.in.gov/fssa/dfcr/</a>   Family and Social Services Administration Phone: (800) 403-0864   Member Services Phone: (800) 457-4584
<b>IOWA – Medicaid and CHIP (Hawki)</b>
Medicaid Website: <a href="http://iowa.gov/Health%20&amp;%20Human%20Services">Iowa Medicaid   Health &amp; Human Services</a>   Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://iowa.gov/Health%20&amp;%20Human%20Services">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a>   Hawki Phone: 1-800-257-8563 HIPP Website: <a href="http://iowa.gov/Health%20&amp;%20Human%20Services">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a> HIPP Phone: 1-888-346-9562
<b>KANSAS – Medicaid</b>
Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>   Phone: 1-800-792-4884   HIPP Phone: 1-800-967-4660
<b>KENTUCKY – Medicaid</b>
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>   Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a> KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a>   Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a>
<b>LOUISIANA – Medicaid</b>
Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
<b>MAINE – Medicaid</b>
Enrollment Website: <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a> Phone: 1-800-442-6003   TTY: Maine relay 711 Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 800-977-6740   TTY: Maine relay 711
<b>MASSACHUSETTS – Medicaid and CHIP</b>
Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>   Phone: 1-800-862-4840   TTY: 711 Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>
<b>MINNESOTA – Medicaid</b>
Website: <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a>   Phone: 1-800-657-3672
<b>MISSOURI – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>   Phone: 573-751-2005
<b>MONTANA – Medicaid</b>
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084   email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>
<b>NEBRASKA – Medicaid</b>
Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633   Lincoln: 402-473-7000   Omaha: 402-595-1178
<b>NEVADA – Medicaid</b>
Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>   Medicaid Phone: 1-800-992-0900

<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 603-271-5218   Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>
<b>NEW JERSEY – Medicaid and CHIP</b>
Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>   Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392   CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710 (TTY: 711)
<b>NEW YORK – Medicaid</b>
Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>   Phone: 1-800-541-2831
<b>NORTH CAROLINA – Medicaid</b>
Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>   Phone: 919-855-4100
<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>   Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>   Phone: 1-888-365-3742
<b>OREGON – Medicaid and CHIP</b>
Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>   Phone: 1-800-699-9075
<b>PENNSYLVANIA – Medicaid and CHIP</b>
Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a>   Phone: 1-800-692-7462 CHIP Website: <a href="#">Children's Health Insurance Program (CHIP) (pa.gov)</a>   CHIP Phone: 1-800-986-KIDS (5437)
<b>RHODE ISLAND – Medicaid and CHIP</b>
Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>   Phone: 1-855-697-4347 or 401-462-0311 (Direct Rlte Share Line)
<b>SOUTH CAROLINA – Medicaid</b>
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>   Phone: 1-888-549-0820
<b>SOUTH DAKOTA – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>   Phone: 1-888-828-0059
<b>TEXAS – Medicaid</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a> Phone: 1-800-440-0493
<b>UTAH – Medicaid and CHIP</b>
Utah's Premium Partnership for Health Insurance (UPP) Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a> Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a>   Phone: 1-888-222-2542   Adult Expansion Website: <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a> Utah Medicaid Buyout Program Website: <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a> CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a>
<b>VERMONT – Medicaid</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427
<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> or <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924

<b>WASHINGTON – Medicaid</b>
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>   Phone: 1-800-562-3022
<b>WEST VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> or <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700   CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>   Phone: 1-800-362-3002
<b>WYOMING – Medicaid</b>
Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>   Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 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](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

# RETIREE FREQUENTLY ASKED QUESTIONS

## Q1. When should I enroll in Medicare?

A1. If, like most people, you become eligible for Medicare at age 65, this seven-month window will surround your 65th birthday. This one-time enrollment period is your first opportunity to sign up for Medicare Part A and/or Part B. This is also your first chance to enroll in a Medicare Advantage plan (Part C) or Part D Prescription Drug plan.

If you miss your eligibility window, you will need to wait until Medicare's GEP (general enrollment period) to enroll in your benefits. You will be subject to Medicare's LEP (Late Enrollment Period), which is a lifetime penalty. If you are still actively working and covered through the employer for health insurance benefits, you have the option to postpone enrollment into your Medicare benefits without penalty until you retire.

## Q2. How do I enroll in Medicare?

A2. About three months before your 65th birthday, you will want to sign up for Medicare. If you have not received your automatic enrollment information in the mail, and if you are not already getting retirement or disability benefits, you can sign up in one of the following ways:

- Call Social Security at (800) 772-1213.
- Visit your local Social Security office. You can use the Social Security Office locator at <https://secure.ssa.gov/ICON/main.jsp> or call (800) 772-1213.
- Fill out a form online (if applying for Medicare only and not Social Security benefits) at <https://secure.ssa.gov/iClaim/rib>. Before you start, gather information on this checklist: <http://www.ssa.gov/hlp/isba/10/isba-checklist.pdf>.

## Q3. Do I have to pay Social Security for Medicare Parts A and B?

A3. Most people receive premium-free Part A if they are age 65 or older and have worked and paid Medicare taxes for at least 10 years. However, if you do not qualify for premium-free Part A, you can purchase it at an additional monthly cost. If you choose NOT to buy Part A, you can still buy Part B when eligible. Part B premiums change each year.

## Q4. How do I determine if I qualify for Medicare?

A4. In general, those who are eligible for premium-free Part A (hospital insurance) and Part B (medical insurance) include individuals who are 65 and have worked 10 years in this country or who have a spouse who has, or individuals who are under 65 and have received Social Security disability benefits for 24 months. If you are receiving Social Security, you are likely already enrolled in Part A and Part B when you turn 65. You can determine whether you're eligible by one of the following:

- Call Social Security at (800) 772-1213. If you are deaf or hard of hearing, please call (800) 325-0778. (Medicare is managed by the Centers for Medicare and Medicaid Services. Social Security works with CMS by enrolling people in Medicare.)
- Visit your local Social Security office. Use the Social Security Office locator at <https://secure.ssa.gov/ICON/main.jsp> or call (800) 772-1213.
- Go online to the Medicare.gov website's Eligibility & Premium Calculator: <https://www.medicare.gov/eligibilitypremiumcalc/#eligibility>.

# RETIREE FREQUENTLY ASKED QUESTIONS (CONT.)

## Q5. I don't qualify for premium-free Part A under Medicare. What does this mean?

A5. Most people get premium-free Part A. However, if you don't qualify for premium-free Part A in your own right, if you are married and your spouse is at least 62 years of age when you attain Medicare eligibility, and they are entitled to premium-free Part A, you can draw from their benefit. Your drawing from your spouse's benefit does not affect their entitlement.

If you do not qualify on your own or through a spouse, you can purchase it at an additional monthly cost. If you choose NOT to buy Part A, you can still buy Part B when eligible. If you do not have Part A, you can enroll in the City's Kaiser Permanente Senior Advantage Part B only option; however, your costs under the plan will be higher.

## Q6. How do I pay for my retiree medical coverage?

A6. P&A Administrative Service, Inc. (P&A) is our Retiree Administrator. Once you retire, you will receive a packet from P&A outlining your payment options, which include payment by check, via their online portal, or through ACH/automatic payments to P&A.

## Q7. How do I set up payment from my RHS account to my medical premiums?

A7. To pay for your medical premiums, you will need to set up direct premium payments from Meritain to your bank account. From there, you will need to visit the P&A website and set up automatic payments from the same bank account.

## Q8. I know that I may be eligible to receive a portion of sick leave pay upon retirement, but how does this work?

A8. Please reference your specific MOU for more details on sick pay conversion.

## Q9. As a Retiree, can I sign up for just dental and vision coverage (no medical)?

A9. Yes, you are not required to elect medical coverage to continue dental and/or vision coverage. Should you elect to drop coverage in any one or all of the City's Retiree Medical, Dental, or Vision plans at the time of retirement (or at a later date), you will not be eligible for reinstatement into those plans at a future date.

## Q10. Will I lose my Dental and Vision when I turn 65 and/or become Medicare-eligible?

A10. No, as long as you continue to make premium payments, you will not lose your Dental or Vision coverage.

## Q11. What benefit options do I have if I am moving out of state after retirement?

A11. The City's medical plans available to Retirees under age 65 and/or not Medicare-eligible consist of Kaiser, Sutter Health, and Western Health Advantage. All plans are HMOs that require members to reside or work within their designated service areas in California. They do not have any service areas outside of California.

Retirees over age 65 and/or who are Medicare-eligible have the choice between Kaiser Permanente Senior Advantage (KPSA) and The Hartford Supplement plans. KPSA is a Medicare Advantage plan and is available to members residing in the KPSA service area within California. The Hartford Supplement plan is available for members nationwide, as long as your doctor accepts Medicare.

## RETIREE FREQUENTLY ASKED QUESTIONS (CONT.)

### Q12. I and/or my Spouse is turning 65 soon. How do I add him/her to my Kaiser Senior Advantage Plan?

A12. 90 days before their 65th birthday, the member needs to be enrolled in Medicare Parts A & B. Once enrolled, you need to complete the group Senior Advantage form and send it to the City for processing. You can obtain the form from the City.

### Q13. What is the Hartford Supplement plan?

A13. The Hartford Supplement plan helps pay some of the health care costs that Original Medicare (Parts A and B) doesn't cover. These gaps include items such as co-payments, co-insurance, and deductibles. The Hartford Supplement plan also includes a Prescription, or Part D, benefit through Express Scripts. Please review the Hartford Supplement benefit summary for more plan details.

### Q14. Can I use the Hartford Supplement plan outside of CA?

A14. Yes, as long as your provider accepts Medicare.

### Q15. Will my benefits change under the Hartford Supplement plan?

A15. Depending on the plan you were previously enrolled in, this may be possible. Medicare benefits can differ from non-Medicare group plan benefits.

### Q16. How do I enroll in the Hartford Supplement plan?

A16. Complete The Hartford enrollment form and return it to the City for processing.

### Q17. If I have more questions regarding the Hartford Supplement plan, whom do I contact?

A17. You can review additional FAQs from The Hartford in the Retiree Information section of the City's website. Should you have further questions, you can call Bay Bridge Administrators (BBA) at (800) 275-2147 or [retireehealth@bbadmin.com](mailto:retireehealth@bbadmin.com).

### Q18. How do I obtain a Form 1095-C for tax purposes?

A18. If you were a full-time employee and retired during the tax year, you will receive a 1095-C form. Thereafter, per the Affordable Care Act (ACA) rules, Form 1095-C is not issued to Retirees, as the form is only required for employees.

# NOTES

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