

CITY OF CHICO



2017 RETIREE & COBRA BENEFITS GUIDE

Effective January 1, 2017 - December 31, 2017

Please Join Us! Open Enrollment Health & Wellness Fair
Wednesday, October 5th
10:00 am - 2:00 pm



MEDICARE PART D ANNUAL NOTICE INCLUDED

Important Notice: Read Carefully

This benefits guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. This guide is not intended to be a complete description of the benefit plans, and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern. City of Chico reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future benefits.

Welcome to Your Benefits Guide

Your benefits are valuable. Make sure you get the most from them by taking the time to understand your options and by selecting the best coverage for you and your family.

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

www.ci.chico.ca.us/human_resources_and_risk_management/OpenEnrollment.asp.

Notice of Creditable Coverage

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 see page 21 for more details.

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Annual Open Enrollment runs October 3 through October 31, 2016 for a January 1, 2017 effective date

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2017 Plan Changes

Please review plan changes below effective January 1, 2017.

Medical—Gender Dysphoria

- Affordable Care Act Section 1557— Final clarification on Section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds of race, color, sex, age, or disability. Under the rule:
 - Individuals cannot be denied health care or health coverage based on their sex, including their gender identity;
 - Individuals must be treated consistent with their gender identity, including in access to facilities;
 - Sex-specific health care cannot be denied or limited only because the person seeking such services identifies as belonging to another gender; and
 - Explicit categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

Prescriptions—Express Scripts

- Changes to Express Scripts exclusions for 2017 (EPO, PPO 90, PPO 80). See page 8.

Dental—Delta Dental PPO

- There are no benefit changes reported by the carrier.

Vision—Vision Service Plan (VSP)

- There are no benefit changes reported by the carrier.

Open Enrollment Health & Wellness Fair

Please join us! Local vendors including fitness clubs, natural foods, and others will be present at the Health Fair answering questions and providing information about wellness and how to stay healthy.

Insurance carriers - Anthem, Delta Dental, VSP, as well as the District's broker, EPIC, will be present to help answer any questions you may have regarding:

- Plans
- Benefits
- High Deductible Health Plan (HDHP)/Health Savings Accounts (HSA)

OCTOBER 5, 2016
10:00 am – 2:00 pm
Council Chambers
421 Main Street
Chico, CA 95928

GIVEAWAYS & RAFFLE PRIZES
given at the health fair!!



Enrollment

What You Need to Do

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

- During the annual Open Enrollment period (October 3 – October 31). Any changes you make during the Open Enrollment period become effective January 1, 2017.
- If you do not wish to make any changes to your benefits, no further action is necessary.

Get Ready to Enroll

1. Review your options, ask questions and talk with your family. If you're thinking of changing medical plans:
 - a. Check with your doctors to find out which plans they participate in.
 - b. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or non-formulary drugs).
 - c. Call the medical plan's Member Services number or visit its website (contact details are on page 19 of this guide).
2. Consider not only your current circumstances but also what may be happening in your life in the future. Outside of the Open Enrollment period, you will not be able to make changes to your benefits unless:
 - a. You have a HIPAA special enrollment event.
 - b. You move out of your EPO service area.
3. Consider the following when choosing a medical plan:
 - a. **What the plans cover.** The Medical Plans section of this guide will help explain what each plan covers.
 - b. **Your estimated usage.** Does your plan choice cover the services you use most or will need in the future adequately?
 - c. **Flexibility in choice of doctors, hospitals and how you receive care.** Each plan may include a different set of doctors or hospitals or have different rules for how to receive care.
 - d. **Verify service areas and provider availability** since all medical plans make ongoing changes during the year.
4. Have the right information handy. When you start the enrollment process, you'll need:
 - a. Your Social Security number.
 - b. The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate. Social Security numbers are required for all dependents over the age of 6 months.
 - c. Proof of dependent eligibility (marriage certificate, domestic partner registration, birth certificate).

How to Enroll

Enrolling by Paper Form

To change your medical plan or add/delete dependent coverage, you must submit a "City of Chico Application for Benefits – Retiree and COBRA Coverage," selecting the coverage you wish to elect.

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

The *Application for Benefits* and the *Medicare Prescription Plan Benefit Election Form* can be located on the City of Chico's website at: (http://www.ci.chico.ca.us/human_resources_and_risk_management/OpenEnrollment.asp) or through contacting Human Resources at (530) 879-7900.

Eligibility & Changes

Eligibility

If you are a Retiree and/or COBRA beneficiary, you may participate in the benefits described in this guide given you meet the City's eligibility criteria. Please contact Human Resources and Risk Management Office at (530) 879-7900 for additional information.

Retiree note: If at the time of your retirement or at any future date, you choose to leave the City's medical plan, you may not re-enroll in the future. On the other hand, if you choose to leave the City's dental and/or vision plan, you and your dependents may be able to re-enroll in the future.

Your Dependents

Your eligible dependents include:

- Your spouse (as defined by applicable state law)
- Your same-sex or opposite sex domestic partner who meets certain criteria (listed below)
- Your children up to age 26

Your children include:

- Your or your domestic partner's natural or adopted children
- Your legal stepchildren
- Children placed in your home for adoption
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

Under no circumstances are you allowed to keep dependents (spouses and/or child(ren)) on your benefits if they are no longer eligible

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

Domestic Partner Eligibility Criteria

If you are enrolling a domestic partner, you must have a valid Declaration of Domestic Partnership on file with the State of California. To be eligible for a California Domestic Partnership, both persons are members of the same sex, OR one or both of the persons is over 62 years of age and one or both meet the eligibility criteria under Title II of the Social Security Act as defined in United States Code, title 42, section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in United States Code, title 42, section 1381 for aged individuals.

Note: *The value of health care coverage provided for a domestic partner or any enrolled dependent children of your domestic partner is treated as income to you for federal tax purposes (and in most cases, state tax purposes). The amounts taxable to you can be substantial. It is recommended you consult with your tax advisor for more information on how this affects you.*

Making Changes

You can change your medical benefit plan during annual enrollment. Coverage will remain in effect for the entire plan year (January 1 – December 31). You cannot change your coverage (i.e. add any family members to your coverage) during the plan year, unless you have a HIPAA special enrollment event, see page 23.

Medical Plans

Your Medical Plans

You have the choice of several medical plans.

- Anthem EPO
- Anthem PPO 90
- Anthem PPO 80
- Anthem Lumenos HDHP (Early Retirees & COBRA participants under 65)

How to Choose the Best Plan for You and Your Family

When choosing a medical plan, it is important to look at your budget, your preferences and the age and health of you and your covered dependents. You should consider the key differences between plan types and choose one that best suits you and your family. The plans differ in the following areas:

- Cost of coverage
- Convenience, covered services, access to providers, ease of use

Health Savings Account

If you are under age 65 and enrolled in the Lumenos High-Deductible Health Plan (HDHP) you will be eligible to open a health savings account (HSA)—a tax-advantaged way to pay for current medical expenses and save for future needs. To learn more, see page 16.

Medical Benefit Summaries – Early Retirees & COBRA

2017 City of Chico - CSAC/Anthem Blue Cross Medical Plans Comparison							
	EPO (Express Scripts Pharmacy)	PPO 90/10 (Express Scripts Pharmacy)		PPO 80/20 (Express Scripts Pharmacy)		Lumenos HDHP (Anthem Pharmacy)	
		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Deductible (individual/family)	\$250 / \$500	None	\$500 / \$1,500	\$250 / \$500		\$3,000 / \$6,000 Deductible applies to all services including prescriptions except preventive care	
Annual Maximum Medical (individual/family)	\$1,250 / \$2,500 includes deductible	\$2,000 / \$6,000	\$5,000 / \$15,000	\$3,250 / \$6,500 includes deductible	\$10,000 / \$20,000	\$3,000 / \$6,000 includes deductible	\$5,000 / \$10,000 includes deductible
Annual Maximum Pharmacy (individual/family)	\$5,350 / \$10,700	\$4,600 / \$7,200	No Limit	\$3,350 / \$6,700	No Limit	Combined with Medical	N/A
Physician / Specialist Office Visits	\$20 copay (deductible waived)	\$10 copay	30%	\$25 copay (deductible waived)	40%	No charge	50%
Preventive Care	No charge (deductible waived)	No charge	Not covered	No charge (deductible waived)	Not covered	No charge (deductible waived)	Not covered
Labs & X-rays	No charge; Preventive care: No charge (deductible waived)	\$10 copay; Diagnostic Testing: 10%; Preventive care: No charge	30%; Preventive care: Not covered	\$25 copay; Diagnostic Testing: 20%; Preventive care: No charge (deductible waived)	40%; Preventive care: Not covered	No charge; Preventive care: No charge, (deductible waived)	50%; Preventive care: Not covered
Room & Board Hospital Inpatient (semi-private)	No charge	10%	30%	20%	40%	No charge	50%
Outpatient Surgery	No charge	10%	30% ¹	Hospital: \$50 + 20%; Ambulatory Center: 20%	40% ¹	No charge	50% ¹
Emergency Room Services (copay waived if admitted)	\$250 copay	10%		20%		No charge	
Ambulance Services	No charge	10%		20%		No charge	
Home Health Care	No charge up to 100 visits per calendar year	10% up to 100 preauthorized visits per calendar year	10%	20% up to 100 preauthorized visits per calendar year	20%	No charge up to 100 preauthorized visits per calendar year	No charge up to 100 preauthorized visits per calendar year
Skilled Nursing Facility	No charge up to 100 preauthorized days per calendar year	10% up to 100 preauthorized days per calendar year	10%	20% up to 100 preauthorized days per calendar year	20%	No charge up to 100 preauthorized days per calendar year	No charge up to 100 preauthorized days per calendar year
Durable Medical Equipment	No charge	10%	30%	20%	40%	No charge	50%
Prescription Drug Copay (Retail Pharmacy - 30 Day Supply)	\$5 G / \$10 B / \$25 NF	\$5 G / \$10 B / \$25 NF	Not covered	\$5 G / \$10 B / \$25 NF	Not covered	No charge	Not covered
Prescription Drug Copay (Mail Order - 90 Day Supply)	\$10 G / \$20 B / \$50 NF	\$10 G / \$20 B / \$50 NF	Not covered	\$10 G / \$20 B / \$50 NF	Not covered	No charge	Not covered
Specialty Drugs (Formerly Self-Administered Injectables)	20% up to \$100 copayment maximum per prescription	30% up to \$150 copayment maximum per prescription	Not covered	30% up to \$150 copayment maximum per prescription	Not covered	No charge	Not covered
Chiropractic Care	\$20 copay (deductible waived) up to 30 visits per calendar year	\$25 copay up to 12 visits per calendar year	30%	\$25 copay up to 12 visits per calendar year	40%	No charge up to 20 visits per calendar year	50%
Acupuncture	\$20 copay (deductible waived) up to 12 visits per calendar year	\$25 copay up to 20 visits per calendar year	\$25 copay	\$25 copay up to 20 visits per calendar year	\$25 copay	Not covered	

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

¹ The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for the applicable coinsurance plus all charges in excess of \$350.

LiveHealth Online

Offers you another choice for those times when you need to see the doctor but just can't get there. Highlights of this service are:

- Immediate access to board-certified doctors online who can diagnose, treat, and prescribe drugs
- Available while you are at home, in the office or anywhere you have an Internet Connection and web cam
- Secure, private, easy to use
- Affordable – members pay plan office visit copay/coinsurance
- No appointment is ever needed

Please note, this service is not meant for emergencies. Please contact Anthem or LiveHealth Online for additional details.

Medical Benefit Summaries – Retirees Over 65

2017 City of Chico - CSAC/Anthem Blue Cross Medical Plans Comparison					
	EPO (Express Scripts Pharmacy)	PPO 90/10 (Express Scripts Pharmacy)		PPO 80/20 (Express Scripts Pharmacy)	
		In Network	Out of Network	In Network	Out of Network
Annual Deductible (individual/family)	\$250 / \$500	None	\$500 / \$1,500	\$250 / \$500	
Co-Insurance	None	10% for most benefits	30% for most benefits	20% for most benefits	40% for most benefits
Annual Maximum Medical (individual/family)	\$1,250 / \$2,500 includes deductible	\$2,000 / \$6,000	\$5,000 / \$15,000	\$3,250 / \$6,500 includes deductible	\$10,000 / \$20,000
Annual Maximum Pharmacy (individual/family)	\$5,350 / \$10,700	\$4,600 / \$7,200	N/A	\$3,350 / \$6,700	N/A
Physician / Specialist Office Visits	\$20 copay (deductible waived)	\$10 copay	30%	\$25 copay (deductible waived)	40%
Preventive Care	No charge (deductible waived)	No charge	Not covered	No charge (deductible waived)	Not covered
Labs & X-rays	No charge; Preventive care: No charge (deductible waived)	\$10 copay; Diagnostic Testing: 10%; Preventive care: No charge	30%; Preventive care: Not covered	\$25 copay; Diagnostic Testing: 20%; Preventive care: No charge (deductible waived)	40%; Preventive care: Not covered
Room & Board Hospital Inpatient (semi-private)	No charge	10%	30%	\$100 + 20%	40%
Outpatient Surgery	No charge	10%	30% ¹	Hospital: \$50 + 20%; Ambulatory Center: 20%	40% ¹
Emergency Room Services (copay waived if admitted)	\$250 copay	10%		20%	
Ambulance Services	No charge	10%		20%	
Home Health Care	No charge up to 100 visits per calendar year	10% up to 100 preauthorized visits per calendar year	10%	20% up to 100 preauthorized visits per calendar year	20%
Skilled Nursing Facility	No charge up to 100 preauthorized days per calendar year	10% up to 100 preauthorized days per calendar year	10%	20% up to 100 preauthorized days per calendar year	20%
Hospice Care					
Routine Home Care & Inpatient Respite Care	No charge up to 100 preauthorized days per calendar year	10%	10%	20%	20%
24 Hour Continuous Home Care & General Inpatient Care	No charge	10%	10%	20%	20%
Durable Medical Equipment	No charge	10%	30%	20%	40%
Prosthetics/Orthotics	No charge	10%	30%	20%	40%
Prescription Drug Copay (Retail Pharmacy - 30 Day Supply)	\$5 G / \$10 B / \$25 NF (NON-PDP)	\$5 G / \$10 B / \$25 NF (NON-PDP)	Not covered	\$5 G / \$10 B / \$25 NF (NON-PDP)	Not covered
Prescription Drug Copay (Mail Order - 90 Day Supply)	\$10 G / \$20 B / \$50 NF (NON-PDP)	\$10 G / \$20 B / \$50 NF (NON-PDP)	Not covered	\$10 G / \$20 B / \$50 NF (NON-PDP)	Not covered
Specialty Drugs (Formerly Self-Administered Injectables)	20% up to \$100 copayment maximum per prescription	30% up to \$150 copayment maximum per prescription	Not covered	30% up to \$150 copayment maximum per prescription	Not covered
Rehabilitative Therapy Services	No charge - Limited to 24 visits per year	\$10 copay	30%	\$25 copay	40%
Chiropractic Care	\$20 copay (deductible waived) up to 30 visits per calendar year	\$25 copay up to 12 visits per calendar year	30%	\$25 copay up to 12 visits per calendar year	40%
Acupuncture	\$20 copay (deductible waived) up to 12 visits per calendar year	\$25 copay up to 20 visits per calendar year	\$25 copay	\$25 copay up to 20 visits per calendar year	\$25 copay

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

¹ The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for the applicable coinsurance plus all charges in excess of \$350.

Prescription Drugs – All Retirees & COBRA

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

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

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

EPO, PPO 90, PPO 80

Express Scripts

Lumenos HDHP

Anthem

Note: Formularies are updated regularly. Please contact Express Scripts or Anthem to obtain updates. Contact information can be found on page 19 of this guide. It’s good to keep checking back to determine if your prescriptions are a part of the formulary.

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

2017 Prescription Formulary Changes (EPO, PPO 90, PPO 80)

Please review the following changes and drug exclusions to the Express Scripts Preferred Drug List. If you are affected by any of these changes, Express Scripts will be directly contacting you prior to January 1, 2017 with additional information and what you need to do.

New 2017 Drug Exclusions

COLCHICINE	KINERET	ORENCIA
TALTZ	ZYCLARA	

New 2017 Non-preferred Drugs

ACCU-CHEK COMPACT BLUE CONTROL SOLUTION	ANALPRAM ADVANCED ANALPRAM-HC 2.5% LOTION	CUPRIMINE
DIFFERIN 0.1% LOTION	FORADIL	LIPTRUZET
MIRAPEX ER 3.75 MG TABLET	OXTELLAR XR	RIOMET
TRELSTAR LA	XTANDI	DAKLINZA*
SOVALDI*		

Prescriptions – Retirees Over 65

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

- Option 1: Express Scripts – Non-Medicare Part D**
 Prescription benefits can be found on page 7 and rates can be found on pages 13 and 14. This prescription plan is the same plan as if you were an active employee and is not a Medicare Part D Plan, however, coverage is creditable. See creditable coverage notice on page 21.
- Option 2: Express Scripts Medicare® (PDP) for EIA – Medicare Part D**
 The City of Chico offers a prescription drug plan (PDP) option through the Medicare Part D program called Express Scripts Medicare® (PDP) for EIA. This drug plan is comparable to the other prescription plan and offers better coverage than a standard Medicare Part D plan. Some added benefits to this plan include lower premium and reduced out of pocket costs.
 The PDP plan is a Medicare Part D Plan and the Formulary listing may be different than the other prescription plan. The City is allowing retirees to choose between the plans based upon the one that best fits your needs. There is a premium rate difference between the two plans. Please review the rates on page 13 and 14 prior to making your selection.
 You are not permitted to be enrolled in two Medicare Part D plans, therefore, if you are enrolled in another Medicare Part D program outside of the City, you will need to choose only one. There is more detailed information on pages 11 and 12 on this Rx plan that will assist in your evaluation of the programs. Rates for these plan options can be found on page 13 and 14.

Medicare PDP Plan	
Copays	\$5 / \$20 / \$50 Rx Plan
Express Scripts Pharmacy Network	Yes
Formulary	Express Scripts Medicare (PDP) Formulary
Cost Share Assistance	Available for those who qualify for low income subsidy
Copays (31 day retail supply)	\$5 Generic / \$20 Brand Name / \$50 Non-Formulary
Rx Out of Pocket Maximum	After your Rx annual costs reach \$4,850, your cost share will decrease to 5%
Rx Deductible	None
Mandatory Generic	No Penalty
Retail Refill Allowance	No allowance. Member can fill up to 90 days at retail

Prescriptions – Retirees Over 65 (cont)

Express Scripts Medicare® (PDP) for EIA – Medicare Part D

Are you eligible for Express Scripts Medicare PDP Plan?

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

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

How the Rx plan works

The following table on page 11 provides a summary of your benefit, including final cost-sharing information when filling prescriptions at a retail pharmacy or mail order. This plan provides coverage across all stages of your benefit (Initial Coverage, Coverage Gap and Catastrophic Coverage).

Initial Coverage Stage - for 2017

You will pay the copays listed on the following page until your yearly drug costs (what you and the plan pay) reach \$3,700.

Coverage Gap Stage - for 2017

After your total yearly drug costs reach \$3,700, you will continue to pay the same copays as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach \$4,950.

Catastrophic Coverage Stage - for 2017

After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,950, you will pay the greater of 5% coinsurance or:

- a \$3.30 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage
- a \$8.25 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage.

Prescriptions – Retirees Over 65 (cont)

Express Scripts Medicare® (PDP) for EIA – Medicare Part D

Cost Share Copays

	Retail 31 day	Retail 60 day	Retail 90 day	Mail Order 90 day
Generic Drug	\$5.00	\$10.00	\$15.00	\$10.00
Preferred Brand Drug	\$20.00	\$40.00	\$60.00	\$40.00
Non-Preferred Brand Drug	\$50.00	\$100.00	\$150.00	\$100.00

Medicare Subsidies

People with limited incomes may qualify for “Extra Help” to pay for their Medicare prescription drug costs. Medicare could pay up to seventy-five (75) percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles and copayments.

You may be eligible if you:

- Are eligible for Medicare Parts A&B
- Beneficiaries may be deemed automatically eligible (Dual Eligible's who qualify for both Medicare & Medicaid), or they may apply through Social Security
- Meet asset/income thresholds as defined by CMS (see table below)

	Marital Status	2016 Annual* Low Income Subsidy (LIS) Limit
Full Subsidy	Single	\$8,780
	Married	\$13,930
All other LIS	Single	\$13,640
	Married	\$27,250

*2017 limits have not been released.

If you are identified by the Centers for Medicare & Medicaid (CMS) as qualifying for Extra Help, you will receive plan cost information in your enrollment Welcome packet.

Prescriptions – Retirees Over 65 (cont)

Express Scripts Medicare® (PDP) for EIA – Medicare Part D

Your Guide to Choosing the Right Plan for You Frequently Asked Questions

Will my medical coverage change?

No, your medical coverage through Anthem will remain unchanged.

When will I receive my new member ID card and other plan materials?

You will receive a Welcome Kit from Express Scripts prior to your effective date. Your Welcome Kit will include your new Medicare prescription drug plan member ID card. You should use this card beginning with the effective date of your prescription drug coverage when filling prescriptions. **(Do not discard your medical coverage ID card; you should continue to use your medical card for any other services.)** Your Welcome Kit will also include other important plan benefit materials, such as a formulary and a pharmacy directory. The Centers for Medicare & Medicaid Services (CMS) requires that Express Scripts send these materials upon your enrollment in a Medicare prescription drug plan.

Note: Because Medicare is an individual benefit, you and your covered Medicare-eligible spouse will each have a unique member ID number and prescription drug plan member ID card. In addition, you will each receive separate communications from Express Scripts Medicare.

Do I need to do anything if I am currently taking a drug that requires prior authorization?

You may currently have a prescription for which you have obtained a prior authorization or prior approval from your current plan. If your medication also requires a prior authorization under your new plan, you may need to obtain a new approval. In some cases, existing authorizations from your current plan may not be carried over into your new plan. Review your formulary when you receive it or call Express Scripts Medicare Customer Service. If you require a new approval, call Customer Service after your membership in the plan becomes effective to start the prior authorization process.

Does enrollment in this plan impact any other coverage I may already have?

Enrollment in this plan may cancel your enrollment in the following types of plans:

- another Medicare Part D plan
- a Medicare Advantage Plan with prescription drug coverage (MA-PD)
- a Medicare Advantage Plan not sponsored by EIA

How do I enroll?

Complete and return the *Medicare Prescription Plan Benefit Election Form*. This form can be found on the City's website at: (http://www.ci.chico.ca.us/human_resources_and_risk_management/OpenEnrollment.asp) or by contacting Human Resources at (530) 879-7900.

How will my coverage work?

As a member of this plan, you may fill prescriptions at either in-network or out-of-network retail pharmacies as of your effective date. Please present your member ID card included in your Welcome Kit to your pharmacist.

Will I pay a late enrollment penalty (LEP)?

The LEP is an amount you may be charged for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare prescription drug plan when they are first eligible or to keep other prescription drug coverage that meets Medicare's minimum standards. You may owe an LEP if you didn't join a Medicare prescription drug plan when you were first eligible for Medicare Part A and/or Part B, and: You didn't have other prescription drug coverage that met Medicare's minimum standards, or you had a break in coverage of at least 63 days. If Express Scripts determines that you owe an LEP or have an existing penalty that needs to be adjusted, Express Scripts will notify you of the change. The EIA has chosen to cover the LEP on the member's behalf.

Health Premiums – Retirees

RETIRES NO Medicare								
<i>Medical Insurance Rates (CSAC/Anthem Blue Cross)</i>								
	EARLY RETIREES (Under Age 65)				RETIRES OVER AGE 65 WITHOUT MEDICARE			
	EPO	90/10	80/20	HDHP	EPO	90/10	80/20	HDHP
Employee Only	584.00	584.00	539.00	380.00	878.00	877.00	809.00	570.00
Employee +1	1,244.00	1,243.00	1,146.00	809.00	1,866.00	1,864.00	1,720.00	1,213.00
Employee +2 or more	1,601.00	1,600.00	1,477.00	1,042.00	2,403.00	2,400.00	2,216.00	1,563.00
<i>Dental Insurance Rates (Delta Dental)</i>								
Employee Only	33.50	33.50	33.50	33.50	33.50	33.50	33.50	33.50
Employee +1	62.90	62.90	62.90	62.90	62.90	62.90	62.90	62.90
Employee +2 or more	108.40	108.40	108.40	108.40	108.40	108.40	108.40	108.40
<i>Vision Insurance Rates (VSP)</i>								
Employee Only	5.47	5.47	5.47	5.47	5.47	5.47	5.47	5.47
Employee +1	10.13	10.13	10.13	10.13	10.13	10.13	10.13	10.13
Employee +2 or more	15.71	15.71	15.71	15.71	15.71	15.71	15.71	15.71
<i>Total Contributions</i>								
Employee Only	622.97	622.97	577.97	418.97	916.97	915.97	847.97	608.97
Employee +1	1,317.03	1,316.03	1,219.03	882.03	1,939.03	1,937.03	1,793.03	1,286.03
Employee +2 or more	1,725.11	1,724.11	1,601.11	1,166.11	2,527.11	2,524.11	2,340.11	1,687.11

RETIRES With Medicare								
<i>Medical Insurance Rates (CSAC/Anthem Blue Cross)</i>								
	RETIRES OVER AGE 65 WITH MEDICARE A & B WITH MEDICARE PDP				RETIRES OVER AGE 65 WITH MEDICARE A & B WITHOUT MEDICARE PDP			
	EPO	90/10	80/20	HDHP	EPO	90/10	80/20	HDHP
Employee Only	504.00	521.00	476.00	N/A	566.00	583.00	539.00	N/A
Employee +1	1,008.00	1,042.00	952.00	N/A	1,204.00	1,241.00	1,145.00	N/A
Employee +2 or more	1,511.00	1,563.00	1,428.00	N/A	1,551.00	1,476.00	1,598.00	N/A
<i>Dental Insurance Rates (Delta Dental)</i>								
Employee Only	33.50	33.50	33.50	N/A	33.50	33.50	33.50	N/A
Employee +1	62.90	62.90	62.90	N/A	62.90	62.90	62.90	N/A
Employee +2 or more	108.40	108.40	108.40	N/A	108.40	108.40	108.40	N/A
<i>Vision Insurance Rates (VSP)</i>								
Employee Only	5.47	5.47	5.47	N/A	5.47	5.47	5.47	N/A
Employee +1	10.13	10.13	10.13	N/A	10.13	10.13	10.13	N/A
Employee +2 or more	15.71	15.71	15.71	N/A	15.71	15.71	15.71	N/A
<i>Total Contributions</i>								
Employee Only	542.97	559.97	514.97	N/A	604.97	621.97	577.97	N/A
Employee +1	1,081.03	1,115.03	1,025.03	N/A	1,277.03	1,314.03	1,218.03	N/A
Employee +2 or more	1,635.11	1,687.11	1,552.11	N/A	1,675.11	1,600.11	1,722.11	N/A

Health Premiums - Retirees

RETIREES With Medicare - Mixed Rates				
<i>Medical Insurance Rates (CSAC/Anthem Blue Cross)</i>				
	RETIREES MIXED MEDICARE WITH MEDICARE PDP			
	EPO	90/10	80/20	HDHP
Employee +1 (1 w/Medicare / 1 w/out Medicare)	1,088.00	1,105.00	1,015.00	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	1,445.00	1,462.00	1,346.00	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	1,365.00	1,399.00	1,283.00	N/A
<i>Dental Insurance Rates (Delta Dental)</i>				
Employee +1 (1 w/Medicare / 1 w/out Medicare)	62.90	62.90	62.90	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	108.40	108.40	108.40	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	108.40	108.40	108.40	N/A
<i>Vision Insurance Rates (VSP)</i>				
Employee +1 (1 w/Medicare / 1 w/out Medicare)	10.13	10.13	10.13	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	15.71	15.71	15.71	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	15.71	15.71	15.71	N/A
<i>Total Contributions</i>				
Employee +1 (1 w/Medicare / 1 w/out Medicare)	1,161.03	1,178.03	1,088.03	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	1,569.11	1,586.11	1,470.11	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	1,489.11	1,523.11	1,407.11	N/A

RETIREES With Medicare - Mixed Rates				
<i>Medical Insurance Rates (CSAC/Anthem Blue Cross)</i>				
	RETIREES MIXED MEDICARE WITHOUT MEDICARE PDP			
	EPO	90/10	80/20	HDHP
Employee +1 (1 w/Medicare / 1 w/out Medicare)	1,150.00	1,167.00	1,078.00	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	1,507.00	1,524.00	1,409.00	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	1,561.00	1,598.00	1,476.00	N/A
<i>Dental Insurance Rates (Delta Dental)</i>				
Employee +1 (1 w/Medicare / 1 w/out Medicare)	62.90	62.90	62.90	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	108.40	108.40	108.40	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	108.40	108.40	108.40	N/A
<i>Vision Insurance Rates (VSP)</i>				
Employee +1 (1 w/Medicare / 1 w/out Medicare)	10.13	10.13	10.13	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	15.71	15.71	15.71	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	15.71	15.71	15.71	N/A
<i>Total Contributions</i>				
Employee +1 (1 w/Medicare / 1 w/out Medicare)	1,223.03	1,240.03	1,151.03	N/A
Employee +2 or more (1 w/Medicare / 2 w/out Medicare)	1,631.11	1,648.11	1,533.11	N/A
Employee +2 or more (2 w/Medicare / 1 w/out Medicare)	1,685.11	1,722.11	1,600.11	N/A

Employee Assistance Program Rate

If you elected the Employee Assistance Program at retirement the monthly premium is \$2.38. This rate includes coverage for all household members.

Health Premiums – COBRA

COBRA				
<i>Medical Insurance Rates (CSAC/Anthem Blue Cross)</i>				
	COBRA			
	EPO	90/10	80/20	HDHP
Employee Only	595.68	595.68	549.78	387.60
Employee +1	1,268.88	1,267.86	1,168.92	825.18
Employee +2 or more	1,633.02	1,632.00	1,506.54	1,062.84
<i>Dental Insurance Rates (Delta Dental)</i>				
Employee Only	34.17	34.17	34.17	34.17
Employee +1	64.16	64.16	64.16	64.16
Employee +2 or more	110.57	110.57	110.57	110.57
<i>Vision Insurance Rates (VSP)</i>				
Employee Only	5.58	5.58	5.58	5.58
Employee +1	10.33	10.33	10.33	10.33
Employee +2 or more	16.02	16.02	16.02	16.02
<i>Total Contributions</i>				
Employee Only	635.43	635.43	589.53	427.35
Employee +1	1,343.37	1,342.35	1,243.41	899.67
Employee +2 or more	1,759.61	1,758.59	1,633.13	1,189.43

Employee Assistance Program Rate

As a COBRA beneficiary you may also elect the **Employee Assistance Program** as a benefit for \$2.43 per month. This rate includes coverage for all household members.

High-Deductible Health Plans & Health Savings Account (HSA) – Retirees Under 65 & COBRA

If you enroll in the Lumenos High-Deductible Health Plan, you are eligible to open your own Health Savings Account (HSA). Health savings accounts were created by the federal government to give people a new way to pay for medical expenses and save for future needs. An HSA is considered “tax-advantaged” because you are not taxed at the federal level on contributions, earnings or withdrawals—and your balance rolls over year to year. You own and manage the account.

You can use your HSA to:

- Pay for current expenses, such as deductibles, prescription drugs, coinsurance or other health care expenses
- Pay for future health care expenses, even if you are no longer enrolled in a High-Deductible Health Plan
- Pay for things other than health care (but you will be taxed on those payments and subject to penalties)

Important Notes:

- **You can contribute to an HSA only if you are enrolled in a qualified High-Deductible Health Plan.** You cannot be covered under any other non-qualified medical plan, including your spouse’s plan.
- **If you have an HSA, you cannot be enrolled in the Health Care Flexible Spending Account** (including coverage under your spouse’s flexible spending account).
- **You cannot contribute to an HSA if you are age 65 or older and enrolled in any type of Medicare.**

The High-Deductible Health Plans and your HSA work together.

High-Deductible Health Plans	Health Savings Account (HSA)
<ul style="list-style-type: none"> • Comprehensive medical coverage after you pay the deductible • Preventive care (before you meet the deductible) • Out-of-network benefits so you can see any doctor • Plan pays a percentage of covered services • Out-of-pocket maximum protects you from high costs 	<ul style="list-style-type: none"> • You can contribute up to the annual limit each year • Helps pay your deductible and other expenses • <i>Tax-free contributions, earnings and payments (for qualified expenses)</i>

Health Savings Account Limits

	For 2016	For 2017
HSA Contribution Limit	Individual: \$3,350 Family: \$6,750	Individual: \$3,400 Family: \$6,750
HSA catch-up contributions (age 55 or older)*	\$1,000	\$1,000

* Catch-up contributions can be made any time during the year in which the HSA participant turns 55.

Dental Plan

Your Dental Plan

The Delta Dental PPO plan gives you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. This plan is a preferred provider organization (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage and benefit from discounted rates.

If you go to a dentist who is out of the network, you receive a reduced level of benefits.

Below is a quick summary of the key features and costs for both in-network and out-of-network services.

Delta Dental		
In / Out of Network		
Calendar Year Deductible	\$15 / \$45	\$25 / \$75
Calendar Year Maximum Benefit	\$1,000	
Diagnostic and Preventive (D & P)	100%	
D & P Exempt from Deductible	No	No
Basic	100%	80%
Crowns and Cast Restorations	80%	
Prosthodontics	50%	
Orthodontia - Adults/Child(ren)	50%	
Calendar Year Orthodontia Maximum	\$500	
Implants	50%	
TMJ Treatment	Not covered	
Waiting Period	None	

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

Vision Plan

Your Vision Plan

City of Chico offers vision coverage through VSP with an extensive network of optometrists and vision care specialists. Under this plan, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will receive a reduced level of benefits.

Here is a summary of covered services and costs:

Copay		CSAC - VSP	
Exam		\$10 copay	
Materials		\$25 copay	
Primary Eye Care		\$20 copay	
Benefit Frequency			
Exam		Every 12 months	
Lenses		Every 12 months	
Frames		Every 24 months	
Coverage		In - Network	Out-of-Network
Eye Exam		Covered in Full	\$45
Single Lens		Covered in Full	\$30
Bi-Focal Lenses		Covered in Full	\$50
Tri-Focal Lenses		Covered in Full	\$65
Lenticular Lenses		Covered in Full	\$100
Standard Progressive Lenses		Covered in Full	\$50
Frame Allowance		\$125	\$70
Costco Frame Allowance		\$65	n/a
Contact Lenses			
Medically Necessary		Covered in Full	\$210 per pair
Elective		\$160	\$105

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

Additional VSP Benefits:

- **Additional Pairs of Glasses** - 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses
- **Additional \$20 frame allowance** to spend on featured frames
- **Primary EyeCare Program** - Supplemental coverage for non-surgical medical eye conditions, such as pink eye and other urgent eyecare - \$20 copay per visit at Preferred Providers
- **Laser VisionCare Program** - Discounts average 15% off the regular price or 5% off a promotional price; discount only available from contracted facilities
- **Eye Health Management Program** - Exam reminder letters sent to VSP members with diabetes who have not had an eye exam in 14 months
- **TruHearing** - You can save up to \$2,000 on a pair of hearing aids with TruHearing pricing. Your dependents and extended family member are eligible, too. Please call TruHearing at (877) 396-7194 for more information Don't forget to mention that you are a VSP member.

Employee Assistance Program (EAP)

The employee assistance program (EAP) offers you and your family information, referrals and short-term counseling for personal issues affecting work or personal life. Referrals are available for childcare services, legal consultations, older adult services and career management.

To contact the EAP, call (800) 227-1060 EAP representatives are available seven days a week, 24-hours a day.

Contacts

If you have questions you can contact the City of Chico Human Resources and Risk Management Office or the plan carriers. Use this chart to help guide you to the right resource on the first try.

Plan Carriers

PLAN	GROUP #	TELEPHONE #	WEBSITE
MEDICAL			
<i>Anthem Blue Cross</i>	Various See I.D Card	(800) 967-3015	www.anthem.com/ca
<i>Anthem LiveHealth Online</i>	N/A	(888) 548-3432	www.livehealthonline.com
Prescription Coverage – Non-High Deductible Health Plans (HDHP)			
<i>Express Scripts</i>	RX4EIAH	(800) 711-0917	www.express-scripts.com
Health Savings Account – High Deductible Health Plans (HDHP) Only			
<i>Sterling HSA</i>	GCA004872	(800) 617-4729	www.sterlinghsa.com
Dental			
<i>Delta Dental</i>	Retiree: 74-0002 COBRA: 74-0003	(800) 765-6003	www.deltadentalins.com
Vision			
<i>VSP</i>	12137687	(800) 877-7195	www.vsp.com
Employee Assistance Program (EAP)			
<i>MHN</i>	cityofchico	(800) 227-1060	www.mhn.com
Retiree and COBRA Billing			
<i>Employee Benefit Specialist (EBS)</i>	N/A	(925) 469-5228	Debra.hopkins@ebsbenefits.com

Glossary of Terms

AD&D (Accidental Death & Dismemberment)	A plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of part of the body, or the loss of the use of part of the body).
Beneficiary	A person designated by a participant, or by the terms of an employee benefit plan, which is or may become entitled to a benefit under the plan.
COBRA	Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring certain employers that offer group health plans to provide continuation coverage to employees and their dependents who incur certain qualifying events.
Co-Insurance or Cost Sharing	The portion of covered health care costs for which you are financially responsible. Coinsurance does not include deductibles or copays.
Co-Payment or Copay	A set amount you pay out of pocket for a particular service. The plan pays the balance.
Deductible	The out-of-pocket amount you must pay each plan year before the plan pays for eligible benefits.
Evidence of Insurability	Many insurance companies require prospective clients/ individuals to prove that they are in good health and are therefore good insurance risks before the company will cover them.
Explanation of Benefits (EOB)	A statement from a plan explaining what portion of a claim was paid.
Generic	Your prescription drug copay depends on the class or group of your prescribed medication. A generic drug generally has the lowest copay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand-name-only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand-name drugs; however, they are much less expensive.
HIPAA Authorization	Under HIPAA, a document that authorizes the use or disclosure of an individual's Protected Health Information as determined by the company.
In-Network Provider	A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.
Negotiated rates	The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are usually less than usual, customary and reasonable (UCR) charges.
Non-preferred brand	Your prescription drug copay depends on the class or group of your prescribed medication. A non-preferred brand-name drug generally has the highest copay level because it is not on the plan's list of preferred drugs. You can find out how different drugs are classified by your plan by visiting the plan's Web site.
Out-of-Pocket Expenses	Copays, deductibles, and other expenses that are not covered by the health plan.
Out-of-Network Provider	A state-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits when you use out-of-network providers. See your plan for coverage details.
Qualified Change in Status	Certain events which may allow you to make allowable changes to your benefits. Qualifying events include: marriage, divorce, death, birth, adoption or placement for adoption, and significant change in employment.
Reasonable and Customary (R&C) or Usual, Reasonable & Customary (UCR)	A term used in many health plans, defined as the price at or below which the majority of health-care professionals of similar expertise charge for similar procedures within a specific geographic area.

Medicare Part D – Creditable Coverage Notice

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

This Notice Applies to You (or Dependent) **ONLY** if such person is (1) enrolled in a group medical plan offered by City of Chico **AND** (2) eligible for 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 City of Chico and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Chico has determined that the prescription drug coverage offered by Anthem Blue Cross is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current City of Chico coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may not be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current City of Chico coverage, be aware that you and your dependents may not be able to get this coverage back.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778)

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that

coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage, contact the person listed at the end of this notice on the following page 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 City of Chico changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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:	October 3, 2016
Name of Entity/Sender:	City of Chico
Contact –Position/Office:	Amber Foster
Address:	411 Main Street Chico, CA 95927
Phone Number:	(530) 879-7906

Important Notices

Notice of Availability of HIPAA Privacy Notice

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. The City offers a variety of health coverage options and choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available for your medical plan which summarizes important information about your health coverage options. The SBCs and a uniform glossary are available on the City's website at: (http://www.ci.chico.ca.us/human_resources_and_risk_management/OpenEnrollment.asp).

A paper copy is also available, free of charge, by emailing Amber Foster in Human Resources.

HIPAA Notice of Special Enrollment Rights for Medical/Health Plan Coverage

If you decline enrollment in a CSAC Excess Insurance Authority's (EIA) 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 a CSAC Excess Insurance Authority's (EIA) 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 [medical plan OR health plan] enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

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

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

Newborns' and Mothers' Health Protection Act Notice

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

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.