



2026 EARLY & MEDICARE ELIGIBLE RETIREES
YOUR LIFE, YOUR BENEFITS

CITY OF
LONG BEACH



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 see the *Important Plan Information Section* for more details.

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BENEFIT COSTS, PLAN CONTACTS, ANNUAL NOTICES



GETTING STARTED

2026 BENEFITS

January 1, 2026
through
December 31, 2026

IMPORTANT NOTE:

This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make this overview comprehensive, it cannot provide a complete description of all benefits. Plan documents contain more details on relevant provisions, limitations, and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Throughout your retirement, the City of Long Beach supports you with benefit package and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your retirement insurance benefits.

You will find tips to help you understand your benefits, save time and money on healthcare, and balance your retirement. Review the coverage and tools available to you to make the most of your benefits package.

BENEFITS OVERVIEW

Participants enrolled in the City’s retiree benefits may have access to the following plans. Reference page 7 for eligibility.

Core Benefits		
<p>Medical Anthem Blue Cross Anthem.com/CA/COLB (844) 653-7399 Policy #: 276800</p>	<p>Medical UnitedHealthcare UHCRetiree.com (877) 714-0178 Policy #: 15647</p>	<p>Medical SCAN SCANHealthPlan.com/COLB (877) 305-7226 Policy #: 119</p>
<p>Dental Delta Dental DeltaDentalins.com/COLB</p> <p>HMO PPO (800) 422-4234 (800) 765-6003 Policy #: 78506 Policy #: 3712</p>	<p>Vision VSP VSP.com (800) 877-7195 Policy #: 30069959</p>	<p>Pharmacy Benefit CVS Caremark Caremark.com (855) 559-7919</p>

Other Benefits*			
*Some of these benefits are only accessible if you had an account when you were an active City of Long Beach employee.			
<p>Long-Term Care Insurance UNUM UnumInfo.com/CityofLongBeach (800) 421-0344</p>	<p>457(b) Plan MissionSquare MissionSq.org/LongBeach (202) 759-7122</p>	<p>Retirement Pension Plan PARS PARS.org (800) 540-6369</p>	<p>Retirement Pension Plan CalPERS CalPERS.CA.gov (888) 225-7377</p>

Resources	
<p>Benefit Concierge Services Health Advocate HealthAdvocate.com/COLB (866) 799-2691</p>	<p>Medicare Resource Alliant Medicare Services AlliantMedicareSolutions.com (877) 888-0165</p>

OPEN ENROLLMENT HIGHLIGHTS



What is changing in 2026?

New Medicare Solutions Resource

We are also pleased to introduce Alliant Medicare Solutions (AMS). We know that navigating Medicare, retirement, and Social Security decisions can feel overwhelming, but you don't have to do it alone. AMS is a no-cost resource available to you, your family, and friends. Experienced, licensed insurance agents can help you understand Medicare, explore enrollment options, coordinate benefits, and prepare for retirement. Get started by calling 877-888-0165 or review your Benefit Guide for more details.

New Medicare Part D Catastrophic Coverage Limit

The Medicare Part D Catastrophic Coverage Limit has increased from \$2,000 to \$2,100 for 2026. This is applicable to SCAN and UHC members' coverage.

WHO'S ELIGIBLE FOR BENEFITS?

Retirees

- Early retirees less than age 65, those not eligible for Medicare, and retired from full time employment as well as retirees 65+ and those eligible for Medicare (must have Medicare Parts A & B) and enrolled in City Benefits prior to retirement.

Eligible Dependents

Eligible dependents are those you either enrolled in your plans at the time of retirement or added for the first time during retirement due to a qualifying life event.

- **Your spouse** – The person who you are legally married to under state law, including a same-sex spouse.
- **Your registered domestic partner** (same or opposite sex, must be age 18 or over)
- **Your child(ren)** – Includes natural children, step-children, domestic partner's children, adopted children, children fostered under legal custody, and children covered under legal guardianship:
 - Under age 26. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
 - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support. See below regarding Disabled Dependents for additional information.
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
- **Disabled (Child) Dependent** – Unlike other dependent children, a disabled dependent child may be eligible for health benefits beyond the age of 26. A disabled child dependent can remain a qualified dependent if the disability is certified by a physician and if it occurred prior to reaching age of 26. Contact your HR-Employee Benefits at Retirement@LongBeach.gov or at (562) 570-6303 for the Disabled Dependent Certification Form.
 - The Anthem Blue Cross Disabled Dependent Certification process must be completed within 60 days of the disabled dependent reaching the age of 26 and requires completion of the Disabled Dependent Certification Form. Once certified by a physician, the Form must be forwarded to CalgEnrollIntake@Anthem.com for review and approval, to avoid coverage interruptions. ***Due to HIPAA, please be advised that the City is not involved in the review and/or approval of Disabled Dependency status.***
- **Pregnant (Child) Dependent** – If you have a covered (child) dependent under your health insurance who is pregnant, the covered (child) dependent is responsible for obtaining health coverage for the baby. The City's plan will only cover prenatal care and delivery for the covered (child) dependent.
 - Please note that the health plan will not cover the children of your dependent (grandchildren) unless you have legal guardianship and/or custody.

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

IMPORTANT NOTE: If you cancel your insurance, you nor your dependents will be able to re-enroll.

2026 RETIREMENT RATES

PLAN	MONTHLY COST
Medical – Anthem Blue Cross PPO	
Single Retiree	\$1,386.98
Retiree with 1 Dependent	\$1,733.75
Retiree with 2 or More Dependents	\$1,822.24
Medical – Anthem Blue Cross Medicare Supplement (Must have Medicare Parts A & B)	
One Medicare (Single)	\$958.18
One Medicare & One Anthem PPO Non-Medicare Dependent	\$1,733.75
One Medicare & Two/More Anthem PPO Non-Medicare Dependents	\$1,822.24
Two Medicare (Retiree & Spouse)	\$1,915.89
Two Medicare & One Anthem PPO Non-Medicare Dependent	\$2,805.79
Two Medicare & Two or More Anthem PPO Non-Medicare Dependents	\$3,372.35
Medical – Anthem Blue Cross Premier HMO – CA ONLY	
Single Retiree	\$1,109.75
Retiree with 1 Dependent	\$1,997.57
Retiree with 2 or More Dependents	\$2,170.50
Medical – Anthem Blue Cross Classic HMO – CA ONLY	
Single Retiree	\$907.84
Retiree with 1 Dependent	\$1,225.60
Retiree with 2 or More Dependents	\$1,344.33
Medical – UnitedHealthcare Group Medicare Advantage PPO (Must have Medicare Parts A & B)	
One Medicare (Single)	\$739.49
Two Medicare (Retiree & Spouse)	\$1,478.98
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,849.24
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$2,588.73
One Medicare & Two Anthem Premier HMO Non-Medicare Dependents	\$2,737.06
One Medicare & Three/More Anthem Premier HMO Non-Medicare Dependents	\$2,909.99
One Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,647.33
Two Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$2,386.82
One Medicare & Two Anthem Classic HMO Non-Medicare Dependents	\$1,965.09
One Medicare & Three or More Anthem Classic HMO Non-Medicare Dependents	\$2,083.82
Medical – SCAN Health Plan Medicare Advantage – CA ONLY (Must have Medicare Parts A & B)	
One Medicare (Single)	\$370.75
Two Medicare (Retiree & Spouse)	\$741.50
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,480.50
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,851.25
One Medicare & Two Anthem Premier HMO Non-Medicare Dependents	\$2,368.32
One Medicare & Three/More Anthem Premier HMO Non-Medicare Dependents	\$2,541.25
One Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,278.59
Two Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,649.34
One Medicare & Two Anthem Classic HMO Non-Medicare Dependents	\$1,596.35
One Medicare & Three/More Anthem Classic HMO Non-Medicare Dependents	\$1,715.08
Dental – Delta Dental of California PPO	
Retiree with or without Dependent(s)	\$105.03
Dental – DeltaCare USA HMO	
Retiree with or without Dependent(s)	\$38.67
Vision – VSP Vision	
Retiree with or without Dependent(s)	\$13.92
Vision – VSP Vision Voluntary 65+ Only	
65+ Retiree Only	\$9.14
65+ Retiree with One Dependent	\$18.29
65+ Retiree with Two or More Dependents	\$21.49

Note: Other combinations of health plan enrollments may be available for non-Medicare retirees with Medicare-eligible dependents, or Medicare-eligible retirees with non-Medicare dependents. Please contact HR-Employee Benefits at Retirement@LongBeach.gov or (562) 570-6303 for additional information.

CHANGING YOUR BENEFITS



When can I enroll?

Coverage for new retirees begins on the 1st of the month following their retirement date. New retirees must advise HR-Employee Benefits of their enrollment selections prior to retirement. **If you do not inform HR-Employee Benefits of your selections, you will not receive coverage.**

Once enrolled, your benefits will remain unchanged until the next open enrollment period, unless a qualifying life event occurs. Make sure to notify HR-Employee Benefits right away if you have a qualifying life event and need to make a change.

If you cancel enrollment

You can cancel at any time with at least a 30-day notice from the 1st of the month by contacting HR-Employee Benefits.

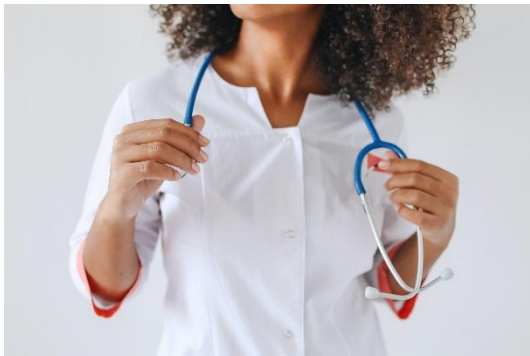
Once you cancel enrollment in one or more of the City’s benefit plans, you cannot re-enroll at a future time. **If you cancel your insurance, you nor your dependents will be able to re-enroll.**

Contact Information

Contact HR-Employee Benefits at Retirement@LongBeach.gov or (562) 570-6303.

Qualifying Life Events	Enrollment Timeframe	Documentation Verification
Birth or adoption of a baby or child	Within 60 days of QLE	<p>You may be required to provide proof of one or more of the following:</p> <ul style="list-style-type: none"> ▪ Marriage Certificate or License ▪ State of California Domestic Partner Affidavit ▪ Birth Certificate ▪ Final decree of divorce ▪ Court Documents showing legal responsibility for adopted/foster children ▪ Provide Medicare Number and Effective Date
Marriage	Within 60 days of QLE	
Divorce	Within 31 days of QLE	
Medicare	<p>Within 3 months of your 65th birthday; or</p> <p>Upon becoming Medicare eligible</p>	

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 have not met your yearly deductible. The preventive care services you will need to stay healthy vary by age, sex, and medical history.

Visit [CDC.gov/Prevention](https://www.cdc.gov/Prevention) 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 Anthem at (844) 653-7399.

EMERGENCIES AND AMBULANCE SERVICES



Emergencies

In or out-of-network, our plans help pay for **medically necessary** emergency and urgent care services. If you go to an in-network facility (hospital or ambulatory surgery center), but later find out that a provider treating you, such as a radiologist, anesthesiologist, or pathologist, does not participate in your plan, the out-of-network provider will be reimbursed directly.

Ambulance Services

Anthem covers ambulance services when one or more of these criteria are met and you are transported:

- By ground ambulance from your home, or from the scene of an accident or medical emergency, to a hospital.
- Between hospitals, including when you are required to move from a hospital that does not contract with the claims administrator to one that does.
- Between a hospital and a skilled nursing facility or other approved facility.
- By air or water ambulance from the scene of an accident or medical emergency, to a hospital.

Coverage includes medically necessary treatment of an illness or injury by medical professionals from an ambulance service. Anthem will not cover ambulance services for non-emergency reasons.

Please note that ambulance services do not contract with health care providers, which means that ambulance services are covered at what is usual and customary.

Occasionally, retirees may receive a bill from the ground ambulance service provider for remaining costs not covered by insurance. This does not apply to air ambulance services, as retirees should never receive a direct bill for those. If a bill is received, it is recommended that retirees contact **Health Advocate** at **(866) 799 2691** for assistance and clarification regarding the charges.

For complete information on how ambulance services are covered under our plans, we encourage you to review your *Summary Plan Description*, located on [anthem.com/ca/colb](https://www.anthem.com/ca/colb).

HEALTH ADVOCATE CONCIERGE SERVICES

Click to play video



CONTACT HEALTH ADVOCATE

Phone

(866) 799-2691

Email

Answers@HealthAdvocate.com

Website

HealthAdvocate.com/COLB

Registration Code

COLBEmployees

**Visit the App Store or Google
Play Store to download the
Health Advocate app!**

Get help from Health Advocate

Health Advocate is a service that provides you and your entire family 24/7 access to confidential one-on-one benefit support at no additional cost to you! Health Advocate experts will answer your questions and take on virtually any healthcare issue, so you and your family get the right care at the right time.

Connect to all your benefits through a single toll-free number

- Health Advocate can answer questions about your entire benefits package.
- If you need to reach a specific benefit provider, Health Advocate can connect you right away.

Support for every medical condition

- Explain health conditions, diagnoses, and treatments; research the latest treatment options.
- Arrange expert second opinions, transfer medical records, and coordinate care and services.

Health Advocate takes the hassle out of healthcare

- Find the right in-network doctors and make appointments.
- Review medical bills to find errors or duplicate charges; resolve complicated claims and billing issues.

Help you stay on top of your health

- Health Advocate will identify and help you schedule any overdue care, tests, or screenings.
- Receive confidential reminders at home about getting the ongoing care you need.



MEDICAL – RETIREES UNDER 65 AND NOT ELIGIBLE FOR MEDICARE

OUR PLANS

ANTHEM CLASSIC HMO PLAN – CA ONLY

ANTHEM PREMIER HMO PLAN – CA ONLY

ANTHEM PPO PLAN

Medical insurance is a vital component of a comprehensive benefits package. It provides coverage for medical expenses, including doctor visits, hospital stays, and preventative care.

We offer three medical plans through Anthem: Anthem Classic HMO, Anthem Premium HMO, and Anthem PPO.

CONTACT INFORMATION

Website

[Anthem.com/CA/COLB](https://www.anthem.com/CA/COLB)

Phone

(844) 653-7399

App

Sydney Health App

ID Card

Yes

ANTHEM MEDICAL PLAN OPTIONS



ABOUT THE HEALTH CARE PROVIDER GROUPS

Here are some things to keep in mind as you weigh your medical plan options:

1. Consider the location of your physician. They should be within a reasonable distance (about 30 miles) of your home or office.
2. **You must select a PCP if you enroll in one of the Anthem Blue Cross HMO plans.** You may choose different PCPs for yourself and each of your family members, if you wish.
3. The Anthem Blue Cross PPO plan has national networks of physicians and hospitals. Network providers are often available when you travel or if your dependents live in other areas.
4. The Anthem Blue Cross HMO plans cover urgent and emergency services outside your service area when you travel.

HMO Plans – CA Only

When you enroll in one of the Anthem Blue Cross HMO plans, you agree to use only Anthem Blue Cross doctors, facilities, and medical groups for all of your medical care. You must choose a Participating Medical Group (PMG) or Independent Physician Association (IPA), and Primary Care Physician (PCP) to manage your care. Anthem Blue Cross covers most services at 100%, with no deductible, as long as you use providers who belong to your PMG/IPA. Office visit copayments are \$20, and there are no claim forms. Any care you receive without approval from your PCP is not covered. Both HMO Plans utilize the Anthem California Care HMO Network. The Premier HMO plan features a lower Out-of-Pocket Maximum and lower copays for chiropractic, acupuncture, and mental health care than the Classic HMO plan.

PPO Plans

The PPO plan offers you access to a large network of physicians who agree to discount their fees for services. Under this plan, you are not required to select a PCP and you can access different physicians and specialists at your own discretion. While you may go to any doctor or hospital each time you need care, your copay or coinsurance will be lowest when you go to an in-network PPO provider. As long as you use providers who participate in the network, your care will be covered at the highest benefit level – 90% for most services after your deductible is met.

You also have the option to see an out-of-network PPO provider, but services are then covered at 50% of Usual, Customary, and Reasonable charges (UCR). Higher deductible amounts apply, and claim forms are required. Some providers may also require payment in full at the time of service. Out-of-network benefits are paid based on 90th percentile of UCR charges, which means the plan pays charges for non-network providers based on fees charged by 9 out of 10 doctors in their geographic area. This means you could receive a bill for any charges over UCR. If the UCR amount is lower than the actual charge, the provider may take a loss or you, the patient, may be responsible for the difference.

Note: If you use non-network providers, Anthem will mail the reimbursement check to you (not to the non-network provider). It is your responsibility to reimburse non-network providers with the money you receive from Anthem.

ANTHEM DEDUCTIBLE AND COPAY OVERVIEW

The chart below outlines the copayment specifications for the Anthem Classic & Anthem Premier HMO plans. You pay the copayment amounts listed below.

	ANTHEM CLASSIC HMO PLAN (CA ONLY)	ANTHEM PREMIER HMO PLAN (CA ONLY)
	In-Network Only	In-Network Only
Calendar Year Deductible^{1,2}		
Individual	\$0	\$0
Family	\$0	\$0
Embedded/Aggregate ²	N/A	N/A
Calendar Year Out-of-Pocket Maximum^{1,3,4}		
Individual	\$1,500	\$1,000
Family	\$4,500	\$3,000
Embedded/Aggregate ³	Embedded	Embedded
Office Visit		
Primary Care	\$20 copay	\$20 copay
Specialist	\$20 copay	\$20 copay
Preventive Services	No charge	No charge
Chiropractic & Acupuncture	\$15 copay (up to 30 visits/year)	\$10 copay (up to 30 visits/year)
Lab and X-ray	\$0 copay	\$0 copay
Urgent Care	\$20 copay	\$20 copay
Emergency Room (copay waived if admitted)	\$100 copay	\$100 copay
Inpatient Hospitalization	\$250 copay	\$0 copay
Outpatient Surgery	\$0 copay	\$0 copay
Mental Health & Substance Abuse		
Inpatient Facility Care	\$250 copay + 20% ⁵	No charge ⁵
Inpatient Physician Visits	No charge	No charge
Outpatient Facility Care	No charge	No charge
Outpatient Physician Visits	\$20 copay per visit ⁵	\$20 copay per visit ⁵

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

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

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

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

⁵Inpatient subject to utilization review; waived for emergency admissions; Outpatient Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review

ANTHEM DEDUCTIBLE AND COPAYMENT OVERVIEW CONTINUED

The chart below outlines deductible and copayment specifications for the Anthem PPO plan. You pay the copayments (\$) outlined below. The coinsurance (%) listed in the PPO plan shows what you pay after the plan's deductible.

	ANTHEM PPO PLAN	
	In-Network	Out-of-Network
Calendar Year Deductible^{1,2}		
Individual	\$150	\$350
Family	\$300	\$700
Embedded/Aggregate ²	Embedded	Embedded
Calendar Year Out-of-Pocket Maximum^{1,3,4}		
Individual	\$2,650	\$0
Family	\$5,300	\$0
Embedded/Aggregate ³	Embedded	Embedded
Office Visit		
Primary Care	\$20 copay	\$40 copay then 50% ⁵
Specialist	\$20 copay	
Preventive Services	No charge	50% ⁵
Chiropractic & Acupuncture	10% ⁵ (up to 34 visits/year combined with Out-of-Network)	50% ⁵ (up to 34 visits/year in/out combined with In-Network)
Lab and X-ray	10% ⁵	50% ⁵
Urgent Care	\$20 copay	\$40 copay
Emergency Room (copay waived if admitted)	\$100 copay	\$100 copay
Inpatient Hospitalization	10% ⁵	\$300 copay then 50%
Outpatient Surgery	10% ⁵	50% ⁵
Mental Health & Substance Abuse		
Inpatient Facility Care	10% ⁶	\$300 deductible then 50% ^{4, 6}
Inpatient Physician Visits	10% ⁴	50% ⁴
Outpatient Facility Care	10%	\$300 deductible then 50% ^{4, 6}
Outpatient Physician Visits	\$20 copay per visit	\$40 deductible then 50% ^{4, 6}

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

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

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






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

⁵After deductible.

⁶Inpatient subject to utilization review; waived for emergency admissions; Outpatient Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review

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.

<p>Anthem 24/7 NurseLine</p> 	<p>Quick answers from a trained nurse.</p> <p>800-337-4770</p>	<ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice 	24/7	\$0
<p>CVS MinuteClinic (Anthem PPO only)</p> 	<p>Walk-in medical clinics with nurse practitioners and physician assistants who specialize in family health care.</p> <p>Visit a CVS MinuteClinic</p>	<ul style="list-style-type: none"> Treat more than 125 minor illnesses & injuries Vaccines, physicals, screenings Write prescriptions, when medically appropriate Treat adults and children 18 months and older 	Office Hours	\$0
<p>LiveHealth Online</p> 	<p>Many non-emergency health conditions</p> <p>livehealthonline.com</p>	<ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns 	24/7	\$0
<p>Office visit</p> 	<p>Routine medical care and overall health management</p> <p>anthem.com/ca</p>	<ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions 	Office Hours	\$20 copay*
<p>Urgent care</p> 	<p>Non-life-threatening conditions requiring prompt attention</p> <p>anthem.com/ca</p>	<ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections 	Office Hours, or up to 24/7	\$20 copay*
<p>Emergency room</p> 	<p>Life-threatening conditions requiring immediate medical expertise</p> <p>anthem.com/ca</p>	<ul style="list-style-type: none"> Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing 	24/7	\$100 copay*

*Additional costs may apply

ANTHEM RESOURCES



FINDING AN ANTHEM PROVIDER

To find a provider in your plan network, please visit Anthem.com/CA/Find-Care.

LiveHealth Online

LiveHealth Online is your telemedicine vendor. You can video call with a board-certified doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7/365 to assess your condition and, if it is needed, they can send a prescription to your local pharmacy. Register online at LiveHealthOnline.com and make sure to download the mobile app.

LiveHealth Online also offers language lines to serve those who speak Spanish, Tagalog, Khmer, and more. To access the language line, indicate the preferred language when speaking to your provider. The provider will then connect to the line for language assistance.

Sydney Mobile App

Use Sydney Health to keep track of your health and benefits, all in one place. Access your plan details, member services, virtual care, and wellness resources. You can also set up an account at Anthem.com/CA/Register to access most of the same features from your computer.

The following programs are available through Sydney Health App:

- **MyHealth Advantage** - Anthem reviews medical history, pharmacy claims and doctor visits, and then connects the dots to find ways to help you avoid health problems, stay healthy, or save money. If they find something you could do to improve your health, you will get a MyHealth Note.
- **Building Healthy Families** - This program offers personalized, digital support through the Sydney Health mobile app or on Anthem.com/CA. This all-in-one program, at no extra cost to you, can help your family grow strong whether you are trying to conceive, expecting a child, or in the thick of raising young children.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call 24/7 NurseLine at (888) 249-3820.

ANTHEM RESOURCES CONTINUED



FINDING AN ANTHEM PROVIDER

To find a provider in your plan network, please visit Anthem.com/CA/Find-Care.

ConditionCare

ConditionCare is a disease management program available to members at no cost. The program provides tools, resources and support with Asthma (pediatric or adult), Chronic obstructive pulmonary disease (COPD), Coronary artery disease, Diabetes, types 1 and 2 (pediatric or adult) or Heart failure. For more details and/or to join, call (866) 962-0957.

Rula

Rula makes it easy to find a virtual, in-network therapist who meets all of your needs. Getting started is easy, with four simple steps:

- **Select Your Therapist** – Visit Rula.com/Anthem and input your therapist preferences so Rula can match you with the right provider.
- **Complete Registration** – Register within 12 hours of selecting your therapist. No changes will be made until after your first appointment (cancel anytime).
- **Verify Your Benefits** – Rula will work with Anthem on the backend and let you know your copay before your appointment.
- **Confirm Your Appointment Time** – You will receive a confirmation notice 1-2 days before your appointment along with a video call link.

CARRUM HEALTH SURGERY BENEFIT

Click to play video



WHERE CAN I GET MORE INFO?

Phone: (888) 855-7806

Web: Info.CarrumHealth.com/COLB

Mobile App: Search Carrum Health in the App Store or Google Play to download the app!



A surgery benefit that's hard to believe!

When it comes to surgery or major medical treatment, you need to know you are getting the best care. That is why the City of Long Beach is sponsoring Carrum Health as a benefit to all **Anthem PPO members**. Carrum makes it easier, more enjoyable, and less expensive to get high-quality healthcare.

Covered surgeries include

- Knee
- Hip
- Elbow
- Oncology
- Spine
- Shoulder
- Cardiac (heart)
- Bariatric (weight loss)

How it works

- **Activate your account**
Answer a few questions about your health history, read profiles of surgeons, and get a detailed estimate of out-of-pocket costs, if any.
- **Meet your care specialist virtually**
A dedicated care specialist will reach out to walk you through the process, learn about you and your goals, and answer all of your questions.
- **Relax as Carrum plans your surgery**
Your care specialist will gather your medical records, submit forms to your surgeon, and plan travel for you and your loved one, if necessary. You will also meet with your surgeon in-person or virtually to ensure surgery is absolutely medically necessary.
- **Receive world-class care**
You will be in the best hands on the day of your surgery and walk away feeling stronger and healthier.
- **Never get a medical bill**
The Carrum Health benefit covers all of the medical costs related to your procedure, so you won't have any surprise bills.



PHARMACY – RETIREES UNDER 65 AND NOT ELIGIBLE FOR MEDICARE

OUR PLANS

CVS CAREMARK HMO PLAN

CVS CAREMARK PPO PLAN

CONTACT INFORMATION

Website

[Caremark.com](https://www.caremark.com)

Phone

(855) 559-7917

App

CVS Caremark Mobile App

ID Card

No

Prescription drug coverage provides a benefit that is important to your overall health.

The City offers a three-tier prescription drug program through CVS Caremark for retirees enrolled in the Anthem Blue Cross HMO and PPO Plan.

Pharmacy details for the SCAN and UHC plans can be found on page 29 of this guide.

PRESCRIPTION DRUG PLAN HIGHLIGHTS



CVS PERKS

- **Vaccines.** Visit any CVS Pharmacy, including CVS Minute Clinic for approved vaccinations. No appointment necessary and no cost to you or your family.
- **Cash Pay Services.** See full list of services and pricing at [CVS.com/MinuteClinic/Services/Private-Lists](https://www.cvs.com/MinuteClinic/Services/Private-Lists) includes physicals, malaria, TB test, Strep throat test, Typhoid, Urine collection, and more.
- **Target.** Members can get their 30-day or 90-day Maintenance Choice refills at any CVS or Target locations.

Diabetes Management (Anthem PPO & HMO Members)

Next-Generation Transform Diabetes Care is customized using your data, including medical and pharmacy claims, lab work and other biometric and demographic information to develop a personal plan based on your risk profile. The program identifies the next best health action you can take for the most positive impact on your A1C levels and overall health.

The Diabetic Bundling Program waives the cost of diabetic supplies when you purchase them on the same day as your insulin. Under this program, diabetic supplies such as syringes and needles would be at a \$0 member cost share if purchased on the same day as the insulin and if the insulin claim is processed first.

Population Health

The City of Long Beach employees are automatically enrolled in the CVS Population Health Program, which is a comprehensive approach to addressing RX and medical gaps. The program's goals include:

- Continuous review of pharmacy claims, medical claims and lab data for a broader view of member's physician care plan.
- Establish a comprehensive member profile including both Rx and medical gaps.
- Identify potential gaps in care for over 100+ conditions
- Support members in all points of therapy, in accordance with their physician care plan.

MinuteClinic (Anthem PPO Members)

MinuteClinic walk-in medical clinics are staffed by nurse practitioners and physician assistants who specialize in family health care. They care for children and adults, every day with no appointment needed, at \$0 copay for Anthem PPO members and their eligible dependents!

While life happens, they can help you feel better. MinuteClinic practitioners can:

- Treat more than 125 minor illnesses & injuries.
- Provide vaccines, physicals, screenings & more.
- Write prescriptions, when medically appropriate.
- Treat adults and children 18 months and older.
- Share records with your primary care provider, with your permission.

CVS CAREMARK PRESCRIPTION DRUG SUMMARY

View your COLB prescription drug benefits, including copay amounts for specific medications, your prescription drug history, and more by registering online at Caremark.com.

PPO members, please note that when you use an out-of-network pharmacy, you must file a claim form with CVS/Caremark; benefit amount paid will be reduced.

	HMO Plans (Premier & Classic)	PPO Plan	
	In-Network Only	In-Network	Out-of-Network
Annual Out-of-Pocket Limit¹			
Individual	Premier: \$1,000 ² / Classic: \$1,500 ²	\$3,950	Unlimited
Family	Premier: \$3,000 ² / Classic \$4,500 ²	\$7,900	Unlimited
Retail- 30 Day Supply			
Generic	\$10 copay	\$10 copay	Not Covered
Preferred Brand	\$25 copay	\$25 copay	
Non-Preferred Brand	\$40 copay	\$40 copay	
Mail Order- 90 Day Supply			
Generic	\$10 copay	\$10 copay	Not Covered
Preferred Brand	\$50 copay	\$50 copay	
Non-Preferred Brand	\$80 copay	\$80 copay	

¹You must meet an annual out-of-pocket limit for your plan to cover benefits at 100%.

²Combined with medical.

IMPORTANT: Brand Name vs. Generic

If you request a brand-name drug when there is a generic equivalent, you must either purchase the generic drug or pay 100% of the difference between the brand-name price and the generic price, plus the generic copayment. The only exception to this rule is if your doctor writes “Dispense As Written,” or “DAW,” on your prescription, in which case the brand-name drug will be dispensed at the brand name formulary or brand name non-formulary copay (depending on the drug).

Avoid paying 2x the cost for 30-day supply

For prescriptions taken on a long-term basis, members will be allowed to obtain three fills of maintenance drugs at a retail pharmacy. For all subsequent fills of the same prescription, you must use CVS Caremark Mail Service Pharmacy or a local retail CVS Pharmacy. If you continue to fill your long-term prescription at a retail pharmacy, you will pay 2x the retail copayment and receive a 30-day supply. Please talk to your doctor about obtaining a 90-day prescription in these cases.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video



THE FORMULARY DRUG TIERS DETERMINE YOUR COST

\$ Generic Drug

\$\$ Brand Name Drug

\$\$\$ Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

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

To find out if a drug is on your plan's formulary, visit Caremark.com or call the CVS customer service number at (855) 559-7917.

CVS Caremark App

The CVS Caremark app lets you refill mail service prescriptions, track order status, view prescription history and more. If you already use Caremark.com, your existing username and password will also work on the app. If not, you can register directly on the app and use your new username and password on the website.

Features include:

- Refill mail service prescriptions without registering or signing in (Easy Refill).
- Submit new mail order prescription.
- Check order status.
- Check drug costs and coverage.
- View prescription history.
- Find a pharmacy in your network.
- Identify unknown pills.
- Check potential drug interactions.



MEDICAL – RETIREES 65+ AND THOSE ELIGIBLE FOR MEDICARE (MUST HAVE PARTS A & B)

OUR PLANS

SCAN MEDICARE ADVANTAGE

UNITEDHEALTHCARE MEDICARE ADVANTAGE PPO

ANTHEM MEDICARE SUPPLEMENT

Medicare is health insurance for people aged 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicare Part C (Combines Part A and Part B Coverage)
- Medicare Part D (Prescription Drug Coverage)

The City of Long Beach offers you a total of three choices; two Medicare Advantage Plans and one Medicare Supplement Plan. The two Advantage plans offered are the UnitedHealthcare Group Medicare Advantage (PPO) plan and the SCAN Medicare Advantage (HMO) plan. We also offer the Anthem Blue Cross Medicare Supplement plan. Medicare eligible retirees must have Medicare Parts A & B.

Note: Details regarding our plans for Medicare eligible retirees can be found on the following pages. For the most current Medicare rates and information, please visit [Medicare.gov](https://www.Medicare.gov).

MEDICARE COSTS AND HIGHLIGHTS

Medicare Part A helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care. You must meet certain conditions to get these benefits. Cost: You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. For 2025, you pay up to \$518* each month if you don't get premium-free Part A. If you pay a late enrollment penalty, this amount is higher. In most cases, if you choose to buy Part A, you must also purchase Part B and pay monthly premiums for both.

Medicare Part B helps cover doctors' services, hospital outpatient care, and home health care. Medicare Part B is optional. You must elect to enroll in Part B and pay a monthly premium. Your monthly premium depends on your income. Part B also covers some preventive services. Cost: Most people pay the standard premium amount (\$185.00* each month in 2025). However, if your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you could pay more. Premium amounts can change each year depending on your income. Your 2025 Medicare Part B premium amounts* are listed below.

File Individual Tax Return	File Joint Tax Return	You Pay Each Month*
\$106,000 or less	\$212,000 or less	\$185.00
Above \$106,000 up to \$133,000	\$212,000 - \$266,000	\$259.00
Above \$133,000 up to \$167,000	\$266,000 - \$334,000	\$370.00
Above \$167,000 up to \$200,000	\$334,000 - \$400,000	\$480.90
Above \$200,000 up to \$500,000	\$400,000 - \$750,000	\$591.90
\$500,000 or more	\$750,000 or more	\$628.90

Medicare Advantage Plans (Part C) are another way to get your Medicare benefits. They combine Part A, Part B, and, sometimes, Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services. The City of Long Beach offers two Medicare Advantage Plans, UnitedHealthcare Group Medicare Advantage (PPO) and SCAN Health Plan. To participate in a Medicare Advantage plan you must be enrolled in Original Medicare, Part A & B.

Medicare Part D is a prescription drug option run by Medicare-approved private insurance companies to help cover the cost of prescription drugs. How it works: Each year, the member is required to meet a deductible (not more than \$615 in 2026) before their Prescription Drug Plan begins to pay its share of covered drugs (some Medicare drug plans don't have this deductible). After you reach your full deductible (if your plan has a deductible), you'll pay 25% of the cost as coinsurance for your generic and brand-name drugs until your out-of-pocket spending on covered Part D drugs reaches \$2,100 in 2026 (including your deductible and certain payments made on your behalf, like through the Extra Help program). Then, you'll automatically get "catastrophic coverage." You won't have to pay out-of-pocket for covered Part D drugs for the rest of the calendar year.

You will receive enrollment information from Medicare in the months prior to you turning 65. If you are covered by the Anthem Blue Cross Medicare Supplement Plan, you do not have to enroll in Medicare Part D, however you have the option to enroll. You should notify HR-Employee Benefits at (562) 570-6303 or at Retirement@LongBeach.gov to let them know you now have a Medicare Part D plan. Once you have enrolled in a Medicare Part D and wish to change plans, the enrollment period is October 15th through December 7th of each year.

Note: When you enroll in either the SCAN Health Plan or UnitedHealthcare Group Medicare Advantage (PPO), you DO NOT need to enroll in Medicare Part D through Centers for Medicare & Medicaid Services (CMS), as SCAN or UnitedHealthcare will automatically enroll you in Medicare Part D upon completion of the SCAN or UnitedHealthcare Retiree application.

Note Regarding Medicare Part B: For each 12-month period you delay enrollment in Medicare Part B, you will have to pay a 10% Part B premium penalty.

*As of release of this guide, 2026 limits and/or amounts have not been announced.

MEDICARE ADVANTAGE PLANS



LOG IN TO CARRIER WEBSITES FOR ADDITIONAL INFORMATION

- SCAN Members:
SCANHealthPlan.com/COLB
- UnitedHealthcare Members:
UHCRetiree.com

SCAN Health Medicare Advantage (HMO) Plan

The SCAN Health Plan Medicare Advantage Plan offers a network of Primary Care Physicians, specialists, and hospitals. You must use plan providers, except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor SCAN Health Plan will be responsible for the costs. Eligible members must use network pharmacies to access their prescription benefit except under non-routine circumstances.

UnitedHealthcare Group Medicare Advantage (PPO) Plan

The UnitedHealthcare Group Medicare Advantage (PPO) plan is a Medicare Advantage plan that delivers all the benefits of Original Medicare (Part A & B), includes prescription drugs (Part D), and offers additional benefits and features.

With the Medicare Advantage PPO plan, you are not required to select a Primary Care Provider (PCP) and there is no referral needed to see a specialist. The plan also offers you access to a large network of participating providers who accept Medicare assignments and will submit claims directly to UnitedHealthcare for payment, not Medicare.

SCAN AND UNITEDHEALTHCARE DEDUCTIBLE AND COPAY OVERVIEW

The chart below outlines deductible and copayment specifications of the SCAN and the UnitedHealthcare plans. You pay the copayments (\$) outlined below.

	SCAN Health Plan Medical Advantage Plan	UnitedHealthcare Group Medicare Advantage Plan	
	In-Network Only	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum	\$3,400	Unlimited	Unlimited
Office Visit Primary Care Specialist	\$5 copay \$5 copay	No charge	No charge
Preventive Services	No charge	No charge	50% ⁵
Chiropractic	\$5 copay (up to 20 visits/year)	No charge ¹	No charge ¹
Acupuncture	Not covered	No charge ¹	No charge ¹
Lab and X-ray	No charge	No charge	No charge
Urgent Care	\$25 copay	No charge	No charge
Emergency Room (copay waived if admitted)	\$50 copay/visit	No charge	No charge
Inpatient Hospitalization	No charge	No charge	No charge
Outpatient Surgery	No charge	No charge	No charge
Mental Health & Substance Abuse Inpatient Outpatient	No charge ³ \$5 copay/visit	No charge ³ No charge	No charge ³ No charge
Routine Dental Benefits	Provided through the DeltaCare network. \$0 copay/exam (1 per year) \$0 copay/cleaning (2 cleanings/year) \$0 copay dental x-ray (1 x-ray/6 months)	Not Included. Dental benefits are limited to what is covered by Medicare	Not Included. Dental benefits are limited to what is covered by Medicare
Routine Vision Benefits	Provided by EyeMed. \$3 copay/exam (1 per year) \$0 copay/glasses or contacts (1 pair/2 years) \$100 allowance for frames or \$130 allowance for contacts (every 2 years)	No Charge (coverage for Medicare-covered eye exam and routine eye exam refraction only)	No Charge (coverage for Medicare-covered eye exam and routine eye exam refraction only)
Routine Hearing Benefits	\$5 copay/routine exam (1 per year) \$5 copay/hearing aid fitting evaluation (3 visits within the first year of purchase) \$2,000 hearing aid allowance (every 2 years)	\$0 copay/exam (1 per yr) \$500 routine hearing aid combined device allowance (every 3 yrs)	Not Included

¹Medicare-covered Chiropractic/Acupuncture Visits only

² You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan.

³ Limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital

SCAN AND UNITEDHEALTHCARE PRESCRIPTION DRUG COVERAGE

SCAN Health Plan Medicare Advantage Plan

Pharmacy

Tier 1: Preferred Generic	\$7 copay
Tier 2: Generic	\$7 copay
Tier 3: Preferred Brand ¹	\$14 copay
Tier 4: Non-Preferred Brand	\$14 copay
Tier 5: Specialty	\$40 copay
Supply Limit	30 days

Mail Order

Tier 1: Preferred Generic	\$14 copay
Tier 2: Generic	\$14 copay
Tier 3: Preferred Brand	\$28 copay
Tier 4: Non-Preferred Brand	\$28 copay
Tier 5: Specialty	Not Offered
Supply Limit	100 days

¹Select brand medications for diabetes and heart conditions are covered at an \$11 copay.

SCAN members can save on 100-day supply

Get a 3-month supply (100 days) of Tiers 1, 2, 3, and 4 drugs at either a Retail Pharmacy or SCAN Mail-Order Pharmacy and only pay for 2 months. This network offers SCAN members lower copayments for many drugs.



UnitedHealthcare

Group Medicare Advantage (PPO) Plan

Pharmacy

Tier 1: Generic	\$10 copay
Tier 2: Preferred Brand	\$25 copay
Tier 3: Non-Preferred Drugs	\$40 copay
Tier 4: Specialty	\$40 copay
Supply Limit	30 days

Mail Order

Tier 1: Generic	\$20 copay
Tier 2: Preferred Brand	\$50 copay
Tier 3: Non-Preferred Drugs	\$80 copay
Tier 4: Specialty	\$80 copay
Supply Limit	90 days

Save on Maintenance Medications

If you take maintenance medications for conditions such as high blood pressure or diabetes, you can save money by purchasing your prescriptions through mail order. For two copays, you receive a 90-day supply rather than a 30-day supply.

If you reach the Catastrophic Phase, then you will pay the following for prescription drugs:

- \$0 for generics and brand name.

Once you've spent \$2,100 out-of-pocket in 2026, you're out of the coverage gap. Once you get out of the coverage gap (Medicare prescription drug coverage), you automatically get "catastrophic coverage." This assures you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year. Go to [Medicare.gov](https://www.medicare.gov) for more information.

UHC MEMBER RESOURCES



VIRTUAL VISITS – DOCTOR ON DEMAND AND AMWELL

- Sign in at Retiree.UHC.com with your username and password.
- Click on the Virtual Visits toolbox to view your virtual provider group choices, access their websites and set up an appointment.
- Virtually connect with a doctor, nurse, or behavioral health specialist for as low as \$0. Visit UHCVirtualRetiree.com for more information.

UNITEDHEALTHCARE HEARING PROGRAM

- Members have access to a full range of hearing health services with more than 2,000 hearing aid models and styles from top brands.
- Be able to get accessible and more affordable hearing aids with pricing starting at \$699.

UnitedHealthcare Healthy at Home

UnitedHealthcare Healthy at Home program is a program offering the following benefits up to 30 days following all inpatient and skilled nursing facility discharges:

- 28 home-delivered meals through Mom’s Meals when referred by a UnitedHealthcare Advocate.
- 12 one-way rides via Logisticare to medically related appointments and to the pharmacy when referred by a UnitedHealthcare Advocate.
- 6 hours of in-home personal care through CareLinx up to 30 days after discharge. A personal caregiver will help perform tasks such as preparing meals, bathing, medication reminders and more. A referral is not required.
- A new referral is required after every discharge to access your meal and transportation benefit.

Optum HouseCalls

The Optum HouseCalls program offers a clinical preventive care check-in in the privacy of your own home. At no cost to you, HouseCalls include:

- One 45-60 minute at-home visit from your health care practitioner, each year.
- A head-to-toe exam, health screenings and time to talk about any health questions.
- A custom care plan made just for you.
- Review medications.
- Help connect you with additional care you might need.
- Visit Retiree.UHC.com or call (866) 447-7868.

SCAN MEMBER RESOURCES



COGNIFIT – SMARTPHONE APP

- Helps retirees remember their doctor's advice.
- This app securely records the doctor's visits and retirees receive an interactive transcript of the medical parts of the conversation.
- Retirees can work with their healthcare provider to determine what to record.
- Uses HIPAA-compliant servers to protect your privacy and data.

HEADSPACE – PERSONAL GUIDE

- Your personal guide containing hundreds of exercises for meditation, sleep, focus and movement.
- Mindfulness has been shown to help people relieve stress, increase focus, and sleep more soundly.

Independent Living Power

SCAN Health Plan offers unique in-home services designed to keep retirees on Medicare healthy and independent. Called Independent Living Power, these services can help you during recovery from a hospital stay or provide support during a long-term illness. For many retirees, these benefits provide the extra help necessary to remain out of a nursing home. Qualifying members are eligible for up to \$1,250 per month of these additional services:

- Personal care coordinator
- Home delivered meals
- Emergency response system
- Enhanced routine transportation
- Transportation escort
- Homemaker service
- Inpatient custodial care
- In-home caregiver relief

Nurse Advice Line

- Get medical advice from specially trained registered nurses to help access medical problems and provide advice over the phone.
- They can help treat your symptoms and provide aid on finding care.
- Available 24/7, 7 days a week – at no cost to you!
- To reach an advice nurse call: (855) 431-5537.

SCAN Home-Delivered Meals

- Receive up to 28 days of home delivered meals available to members with chronic conditions.
- These meals help members maintain a nutritionally balanced lifestyle while recovering after a hospital stay.
- Fully prepared meals are delivered to your doorstep.
- Health specific menu options are available such as lower sodium, diabetic-friendly, etc.

Urgent Care & Behavioral Telehealth

- Received on-demand care for urgent care and behavioral health.
- Available 24 hours a day, 7 days a week
- Visit [DoctorOnDemand.com/SCAN](https://www.DoctorOnDemand.com/SCAN) to set up your account and get started.

MEDICARE SUPPLEMENT PLAN

Anthem Medicare Supplement Plan

The Anthem Medicare Supplement Plan works in combination with Original Medicare (Parts A & B) and is specifically designed to help cover gaps in healthcare costs that Medicare does not pay, such as copayments, coinsurance, and deductibles. This supplemental coverage provides you with greater financial protection and peace of mind by reducing unexpected out-of-pocket expenses.



LOG IN TO CARRIER WEBSITE FOR ADDITIONAL INFORMATION

- Anthem.com/CA/COLB

ANTHEM BLUE CROSS MEDICARE SUPPLEMENT DEDUCTIBLE OVERVIEW

	Anthem Blue Cross Medicare Supplement	
	In-Network	Out-Of-Network
Calendar Year Out-of-Pocket Maximum	Unlimited	Unlimited
Office Visit	No Charge; plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Outpatient X-ray & Lab	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays Medicare deductible + remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Home Health Care	20% after a \$50 calendar year deductible up to a lifetime maximum of \$5,000 (100 visits per calendar year)	
Preventive Services	Medicare will cover one-time preventive physical exam within the first 6 months that you have Medicare Part B. Routine physicals are not covered.	
Chiropractic Care	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Acupuncture	Not Covered	Not Covered
Inpatient Hospitalization	No Charge; Days 1-60: Medicare deductible paid at 100% Days 61-90: All Covered Expenses not payable by Medicare will be paid at 100% Days 91-100: All Covered Expenses not payable by Medicare will be paid at 100% Days 101+: Not Covered	No Charge; Days 1-60: Medicare deductible paid at 100% Days 61-90: Medicare deductible paid at 100% Days 91-100: Plan pays the usual charges for semi-private room services for the hospital concerned Days 101+: Not Covered
Outpatient Surgery	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Emergency Room (copay waived if admitted)	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Durable Medical Equipment	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Physical Therapy	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Skilled Nursing Facility	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare up to the plan limit of 100 days	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit. No plan benefit is payable after the 100 th day.
Hospice Care	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Inpatient Mental Health & Substance Abuse	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Outpatient Mental Health & Substance Abuse	No Charge; Plan pays 100% of the eligible charges for the service subject to a \$250 calendar year maximum	Plan pays the Medicare deductible and any applicable coinsurance for a confinement at a Medicare-participating hospital

PRESCRIPTION DRUGS – MEDICARE SUPPLEMENT PLAN SUMMARY



CVS Caremark Prescription Drug Coverage

Prescription drugs are covered under CVS Caremark. If you purchase prescription drugs out-of-network and need reimbursement, you must submit a completed claim form and receipt(s) to CVS Caremark. You must submit your claim for reimbursement within one year of the date that the prescription was filled.

If you purchase prescription drugs out-of-network and need reimbursement, you must submit a completed claim form and receipt(s) to CVS Caremark. If you are not enrolled in a Medicare Part D plan, you must submit your claim for reimbursement within one year of the date that the prescription was filled.

You can also print the flip book version of the claim form from alliantbenefits.cld.bz/CVSRxClaimForm

Please note: If you are enrolled in Medicare Part D, your benefits may be coordinated under the medical plan (based on retail cost of the drug) and you must submit claims for prescription drugs within three years of the date that the prescription was filled.

For more information on Medicare Part D creditable drug coverage, visit page 52.

CVS Caremark Prescription Drugs – Medicare Supplement Plan

Pharmacy

Generic	\$10 copay
Preferred Brand	\$25 copay
Non-Preferred Drugs	\$40 copay or 30%
Supply Limit	30 days

Mail Order

Generic	\$10 copay
Preferred Brand	\$50 copay
Non-Preferred Drugs	\$80 copay or 30%
Supply Limit	90 days



DENTAL

OUR PLANS

DELTA DENTAL DELTACARE USA HMO
DELTA DENTAL PPO

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: preventative, basic, major, and orthodontia.

We offer two dental plans through Delta Dental: the Delta Dental HMO and Delta Dental PPO.

CONTACT INFORMATION

Website

[DeltaDentalins.com/COLB](https://www.DeltaDentalins.com/COLB)

Phone

HMO: (800) 422-4234

PPO: (800) 765-6003

App

Delta Dental Mobile App

ID Card

Yes

DELTA DENTAL PLAN OPTIONS



DeltaCare USA HMO Plan – CA Only

When you enroll, you choose a dentist who belongs to the DeltaCare USA HMO network of providers. DeltaCare USA HMO dentists are in most areas of California. When you use the dentist, you select at the time you enroll, treatments are covered at the stated copay. However, if you use any other dentist, you receive no benefits. Each dependent may choose a different dentist and claim forms are not required. The copay schedule is available on [DeltaDentalins.com/COLB](https://www.DeltaDentalins.com/COLB).

Delta Dental PPO Plan

The Delta Dental PPO plan allows you to use any dentist of your choice. Your out-of-pocket costs are determined by the dentist you use - a Delta PPO dentist, Delta Premier Dentist, or an out-of-network dentist. It is to your advantage to select a dentist who participates in the Delta PPO or Premier network. For care from Delta PPO directory providers, you pay no deductible, and the plan pays a plan year max of \$2,000.

When you use a Delta “Premier” dentist or an out-of-network dentist, you first pay a deductible, then the plan pays a percentage of your costs up to \$1,000 each plan year in covered benefits. However, by using one of the many Delta dentists throughout California, you will have a lower fee than you would receive from an out-of-network dentist.

DELTA DENTAL PLAN HIGHLIGHTS



MOBILE RESOURCES

Delta Dental’s mobile website and mobile application allows members to:

- Find a Dentist
- View your benefits, eligibility, deductibles and maximums
- Check claims
- Visit [DeltaDentalins.com/COLB](https://www.DeltaDentalins.com/COLB) or download the mobile app today!

SmileWay

Teeth and gums are tied to your overall wellness. Gum Disease and tooth decay are associated with a number of systemic conditions, and members with cancer, diabetes, heart disease, or certain other chronic conditions may benefit from additional teeth and gum cleanings. If you have are enrolled in the City’s PPO Plan, have a covered medical condition, and opt in to the SmileWay benefit, you will receive additional cleaning benefits each year.

Visit [DeltaDentalins.com/Members/Smileway-Wellness-Benefits.html](https://www.DeltaDentalins.com/Members/Smileway-Wellness-Benefits.html) to learn more about the benefit and opt in.

Member Discounts and Perks

Delta Dental members have access to:

- Many different health & wellness, entertainment, travel, and lifestyle discounts through LifePerks
- LASIK discounts through QualSight
- Hearing aid discounts through Amplifon

To access these programs and more, visit [DeltaDentalins.com/MemberPerks](https://www.DeltaDentalins.com/MemberPerks).

Diagnostic & Preventive (D&P) Waiver Program

Protect your teeth and your wallet with the Diagnostic & Preventive Waiver Program. This program promotes good oral health and may reduce the need for more expensive restorative dental services that can result from undetected oral or related health problems. Under the program, the annual maximum is waived for you and your dependents when diagnostic or preventive services are obtained through a Delta Dental PPO provider. Please see the chart below for an example of how the Waiver Program works.

Visit [DeltaDentalins.com/COLB](https://www.DeltaDentalins.com/COLB) for more information.

Without D&P Maximum Waiver			
Dental Treatment	Delta Dental Pays	Enrollee Pays	Max Remaining
D&P*	\$350	\$0	\$1,650

With D&P Maximum Waiver			
Dental Treatment	Delta Dental Pays	Enrollee Pays	Max Remaining
D&P*	\$350	\$0	\$2,000

* Includes exams, x-rays, cleanings covered at 100% for 2 visits

DELTA DENTAL DEDUCTIBLE AND COPAY OVERVIEW

The chart below outlines deductible and copayment specifications of the Delta Dental HMO and PPO plans. You pay the copayments (\$) outlined below. The coinsurance (%) listed in the PPO plan shows what you pay after the plan's deductible has been met.

	DELTACARE USA HMO	DELTA DENTAL PPO ¹		
	In-Network Only	PPO Dentists	Premier Dentists	Non-Delta Dental Dentists
Annual Deductible				
Individual	\$0	\$0	\$50	\$50
Family	\$0	\$0	\$150	\$150
Annual Plan Maximum²	N/A	\$2,000 per individual	\$1,000 per individual	\$1,000 per individual
Waiting Period	N/A	Late entrants only: 12 months for Major Services and Orthodontics	Late entrants only: 12 months for Major Services and Orthodontics	Late entrants only: 12 months for Major Services and Orthodontics
Diagnostic & Preventive	\$0-\$45 copay based on service	No charge	No charge	No charge
Basic Services				
Restorative	\$0-\$195 copay based on service	20%	20% ³	20% ³
Endodontics	\$0-\$220 copay based on service	20%	20% ³	20% ³
Periodontics	\$0-\$195 copay based on service	20%	20% ³	20% ³
Major Services (Includes Prosthodontics)	\$0-\$195 copay based on service	20%	20% ³	20% ³
Dental Implants	Not covered	50%	50% ³	50% ³
Dental Accident	N/A	No charge ⁴	No charge ⁴	No charge ⁴
Orthodontia	\$0-\$1,900 based on service	50%	50% ³	50% ³
Ortho Lifetime Max				
Adults	N/A		\$1,000	
Children			\$2,000	

¹Reimbursement is based on contracted fees for PPO, Premier, and non-Delta dentists.

²Plan year maximums are not cumulative. The maximum benefit you receive under your dental plan cannot exceed \$2,000 per year.

³After Deductible

⁴\$1,000 maximum per person per year



VISION

OUR PLANS

VSP VISION PLAN

CONTACT INFORMATION

Website

[VSP.com](https://www.vsp.com)

Phone

(800) 877-7195

App

VSP Vision Care

ID Card

No

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

You will even find discounts on services like laser vision correction and money off extra glasses and sunglasses. Visit [VSP.com](https://www.vsp.com) to check out these extra savings.

We offer one vision plan through Vision Service Plan.

VSP VISION PLAN HIGHLIGHTS



USING YOUR VSP BENEFITS

- Find a VSP doctor who's right for you at [VSP.com](https://www.vsp.com).
- Review your plan coverage before your appointment.
- At your appointment, tell them you have VSP. There's no ID card necessary, but you can print one on the VSP website or access it through the VSP app.

The City provides vision coverage through Vision Service Plan (VSP). VSP is committed to improving wellness through eye care. VSP Choice network features a broad provider network with substantial access across the United States in a variety of settings.

The VSP Network

You can choose from over 77,000 access points, including the largest national network of independent doctors and nearly 4,900 participating retail chain locations, including Costco. For added convenience, 91% of VSP doctors offer early morning, evening and weekend appointments, and 24-hour access to emergency care. If you prefer to use a non-network provider, this option is still available under our plan; however, the benefit allowances are lower.

The Benefits

As a VSP member, you have access to:

- WellVision Exam – the most thorough eye exam
- Exclusive Member Extras, like rebates, special offers, and promotions
- Eyecare from the best doctors – VSP doctors have met the highest credential requirements
- The perfect pair of glasses from a wide selection of frames to meet your style and budget
- Shop for eyewear online at VSP's [Eyeconic.com](https://www.eyeconic.com)
- Receive the full frame allowance even when you get your prescription filled at Costco, Sam's Club, or Walmart

Extra Savings

Glasses and Sunglasses

- Extra \$20 to spend on featured frame brands more information on the VSP website
- 20% savings on additional glasses and sunglasses, including lens enhancements from any VSP provider within 12 months of your last WellVision Exam

Retinal Screening

- Max \$39 copay on routine retinal screening

Laser Vision Correction

- Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities

VISION DEDUCTIBLE AND COPAY OVERVIEW

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

	VSP Vision Plan	
	In-Network	Out-of-Network
Exams Benefit Additional Exams Frequency	\$0 copay \$20 copay Once every calendar year	Up to \$68 Once every calendar year
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	\$0 copay \$0 copay \$0 copay Once every calendar year	Up to \$45 Up to \$63 Up to \$80 Once every calendar year
Frames Benefit Frequency	\$130 allowance + 20% discount on amount over allowance (\$150 allowance for featured brands) Once every calendar year	Up to \$50 Once every calendar year
Contacts (Elective) Conventional Exam Medically Necessary Frequency	\$130 allowance Up to \$60 copay No charge Once every calendar year	Up to \$100 Up to \$250 Once every calendar year



WELLBEING & BALANCE

OUR PROGRAMS

ALLIANT MEDICARE SOLUTIONS

FITNESS PROGRAMS

DEFERRED COMPENSATION PLAN

LONG TERM CARE (LTC) INSURANCE

Creating a healthy balance is a major factor in leading a happy and productive life.

We offer programs to help you reach your healthy lifestyle goals:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Focus on financial wellbeing

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to have a wonderful retirement.

ALLIANT MEDICARE SOLUTIONS



CONTACT AMS

Phone

(877) 888-0165

Website

AlliantMedicareSolutions.com

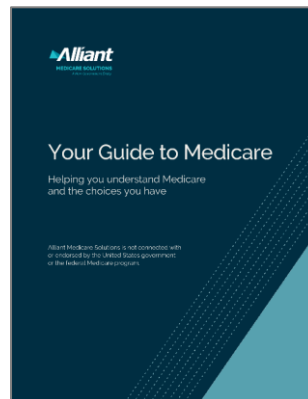
Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Medicare can be complicated. Figuring out the rules, not to mention how Medicare works with or compares to your employer-provided medical coverage, can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

- Call Alliant Medicare Solutions at (877) 888-0165 to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
- Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
- If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Learn more



[Your Guide to Medicare](#)



[Medicare 101](#)



[Social Security Planning](#)

FITNESS PROGRAMS



ADDITIONAL INFORMATION REGARDING FITNESS PROGRAMS

- UHC Plan Members: [SilverSneakers.com](https://www.silver Sneakers.com)
- SCAN Members: [YourOnePass.com](https://www.youronepass.com)

SilverSneakers (UHC Members)

SilverSneakers is more than a traditional fitness program. It's an opportunity to improve your health, gain confidence and connect with your community. Plus, it's included at no additional cost with your UHC health plan. With SilverSneakers, you're free to move in the ways that work for you.

In the gym:

- Thousands of participating locations nationwide with various amenities
- Ability to enroll at multiple locations at any time
- Classes designed for all levels and abilities

At home or on the go:

- LIVE online classes and workshops led by specially trained instructors, 7 days a week
- On-Demand videos available 24/7
- Mobile app with personalized program resources, adjustable workout plans and more

In your community:

- Group activities and classes offered outside the gym
- Events including shared meals, holiday celebrations, and class socials

One Pass (SCAN Members)

Stay active with ONE PASS. Through ONE PASS, SCAN members have access to 25,000+ fitness locations including premium and boutique studios such as Orangetheory, Pure Barre, LIFE Time, Club Pilates, and more.

ONE PASS also offers thousands of on-demand and livestreaming fitness classes, over 20,000 free events and classes, and home fitness kits designed for members who are unable to access a gym location.

457 DEFERRED COMPENSATION PLAN

MissionSquare RETIREMENT

You can keep your City of Long Beach 457 account long after you separate from service or retire. Be sure to meet with your Retirement Plan Specialist to learn more and review options.

By keeping your City of Long Beach 457 Deferred Compensation Plan account, you'll continue to receive benefits, including:

- No cost financial planning access
- Lower investment expenses, on average
- Access to self-directed brokerage account
- Access to your money before age 59 ½ without a penalty*
- Flexible payout options with no taxes until you take withdrawals**

Learn More

Visit 457LongBeach.org/Leaving-Employment for additional information about keeping our City of Long Beach 457 Deferred Compensation Plan account.

Visit 457LongBeach.org or use the QR code to schedule an individual consultation with Tisha Neal, your MissionSquare Retirement Plans Specialist, to discuss your options and how to stay on track to meet your retirement goals. You can also meet with Eric Dobrzynski for Financial Planning Services.

*Withdrawals may begin after separation of service. You lose this automatic exemption if you move to another type of retirement account.

**Applies to all 457 plan contributions and associated earnings.



VISIT 457LongBeach.org



Learn more about the City of Long Beach 457 Deferred Compensation and schedule an individual consultation.



Tisha Neal

Retirement Plan Specialist
(202) 759-7122
TNeal@MissionSq.org



Eric Dobrzynski

Senior Financial Planner
(202) 759-7171
EDobrzynski@MissionSq.org

LONG TERM CARE (LTC) INSURANCE



IMPORTANT NOTE

This coverage is only available to individuals who enrolled prior to February 1, 2026. Enrollment for this benefit is now closed.

Long Term Care Insurance provides financial help if you require care in a nursing facility, in assisted living or at home, as a result of a loss of functional capacity or cognitive impairment due to injury, sickness, or advanced age. Qualifying for benefits is based upon a need for assistance with any two of seven activities of daily living including eating, bathing, dressing, toileting, continence, ambulating, or transferring, and/or cognitive impairment such as dementia or Alzheimer's disease. This coverage is provided by Unum.

The basic plan (Plan 1) provides \$1,000 of monthly benefits for up to three years in a nursing facility. Additional coverage requires health questions and medical underwriting.

Plan "Buy up Options" allow you to increase monthly benefits in units of \$1,000 up to \$8,000 monthly, and to add professional home care and inflation protection, based on the following plan provisions:

PLAN 1

- 3-Year Facility Benefit Duration
- 60-day Elimination Period
- Return of Premium-Reduction
- Long-Term Care Facility

PLAN 2 - Includes all the provisions of Plan 1, in addition to Professional Home Care

PLAN 3 - Includes all the provisions of Plan 1, in addition to 5% Compound Inflation

PLAN 4 - Includes all the provisions of Plan 1, in addition to Professional Home Care and 5% Compound Inflation

The plan is portable and can be taken with you after exhausting unused sick leave (USL) funds. To do so, Unum requires an 'Election to Continue Long Term Care Coverage' form to be completed and submitted within 30 days after coverage ends. Forms may be emailed to GLTCTask@unum.com, faxed to 207-541-7606 or mailed to:

Unum Life Insurance Company of America
Long Term Care Operations
2211 Congress Street
Portland, ME 04122

For assistance, reach out to Kristine Carlew:
KCarlew@acrisure.com

LONG TERM CARE (LTC) INSURANCE RATES

The younger you are, the lower the premium. Premiums are based on age at time of enrollment and the level of benefits selected – the premiums do not increase as you age as long as you remain enrolled in the plan and at the same benefit level chosen at the time of enrollment.

Rate for chosen plan x (Monthly Benefit Amount/\$1,000) = Your Monthly Premium

Age	Plan 1 Base Plan	Plan 2 Base Plan w/ Professional Home Care	Plan 3 Base Plan w/ Compound Inflation	Plan 4 Base Plan w/ Professional Home Care & Compound Inflation
18-30	\$6.70	\$11.10	\$125.80	\$179.70
31	\$6.70	\$11.10	\$127.90	\$182.00
32	\$6.70	\$11.10	\$130.10	\$184.30
33	\$7.20	\$11.60	\$132.20	\$186.50
34	\$7.20	\$11.90	\$134.30	\$188.90
35	\$7.70	\$12.40	\$137.70	\$192.90
40	\$9.60	\$15.10	\$142.10	\$197.60
41	\$10.00	\$15.80	\$144.20	\$200.30
42	\$10.50	\$16.60	\$145.10	\$201.20
43	\$10.90	\$17.20	\$145.90	\$202.20
44	\$11.40	\$18.00	\$146.80	\$203.20
45	\$12.30	\$19.20	\$147.70	\$204.10
46	\$12.80	\$19.90	\$150.00	\$205.00
47	\$13.70	\$20.80	\$152.30	\$205.80
48	\$14.60	\$22.00	\$154.70	\$206.70
49	\$15.50	\$22.90	\$157.00	\$207.60
50	\$16.50	\$24.10	\$159.30	\$208.30
55	\$23.50	\$31.80	\$169.20	\$210.60
60	\$35.10	\$43.60	\$199.00	\$232.20
65	\$60.10	\$68.50	\$225.90	\$251.10
70	\$102.60	\$113.20	\$339.00	\$368.30



IMPORTANT PLAN INFORMATION

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

- 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.

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website	Policy Numbers
Medical	Anthem	(844) 653-7399	Anthem.com/CA/COLB	276800
24/7 Nurseline	Anthem	(800) 337-4770	Anthem.com/CA/COLB	276800
Medical	UnitedHealthcare Group Medicare Advantage (PPO)	(877) 714-0178	UHCRetiree.com	15647
Preventative	Optum HouseCalls	(866) 447-7868	UHCRetiree.com	15647
Medical	SCAN Health Plan	(877) 305-7226	SCANHealthPlan.com/COLB	119
Surgery Benefit (Anthem PPO members only)	Carrum Health	(888) 855-7806	Info.CarrumHealth.com/COLB	N/A
Pharmacy	CVS Caremark	(855) 559-7917	Caremark.com	N/A
Dental	Delta Dental HMO	(800) 422-4234	DeltaDentalins.com/COLB	78506
Dental	Delta Dental PPO	(800) 765-6003	DeltaDentalins.com/COLB	3712
Vision	VSP	(800) 877-7195	VSP.com	30069959
Long-Term Care	UNUM	(800) 421-0344	UnumInfo.com/CityOfLongBeach/Index.aspx	N/A
457 Plan	MissionSquare	(202) 759-7122	MissionSq.org/LongBeach	301910
Medicare Services	Alliant Medicare Solutions	(877) 888-0165	AlliantMedicareSolutions.com	N/A
Benefit Concierge Services	Health Advocate	(866) 799-2691	HealthAdvocate.com/COLB Answers@HealthAdvocate.com	N/A
City of Long Beach Human Resources	City of Long Beach	(562) 570-6303	Retirement@LongBeach.gov	N/A

GLOSSARY

-A-

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 your dependent to temporarily continue healthcare coverage, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums 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.

-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).

-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. 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.

GLOSSARY

-O-

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.

-T-

Telehealth / Telemedicine / Teledoc

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.

Medicare Part D Notice

Important Notice from The City of Long Beach 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 The City of Long Beach 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 Long Beach has determined that the prescription drug coverage offered by the medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, the City of Long Beach 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 the medical plans 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 The City of Long Beach 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 Long Beach 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 Long Beach 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 Long Beach
Contact-Position/Office:	Human Resources
Address:	411 West Ocean Blvd., 10 th Floor, Long Beach, CA 90802
Phone Number:	(562) 570-6303

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (562) 570-6303.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (562) 570-6303.

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 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 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 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City of Long Beach's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

The Anthem HMO Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

For children, you may designate a pediatrician as the primary care provider.

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

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 retiree only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

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

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

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

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

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

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

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

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

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

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

To see if any other states have added a premium assistance program since 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
1-866-444-EBSA (3272)

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

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, and 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 and reference the OMB Control Number 1210-0137.

