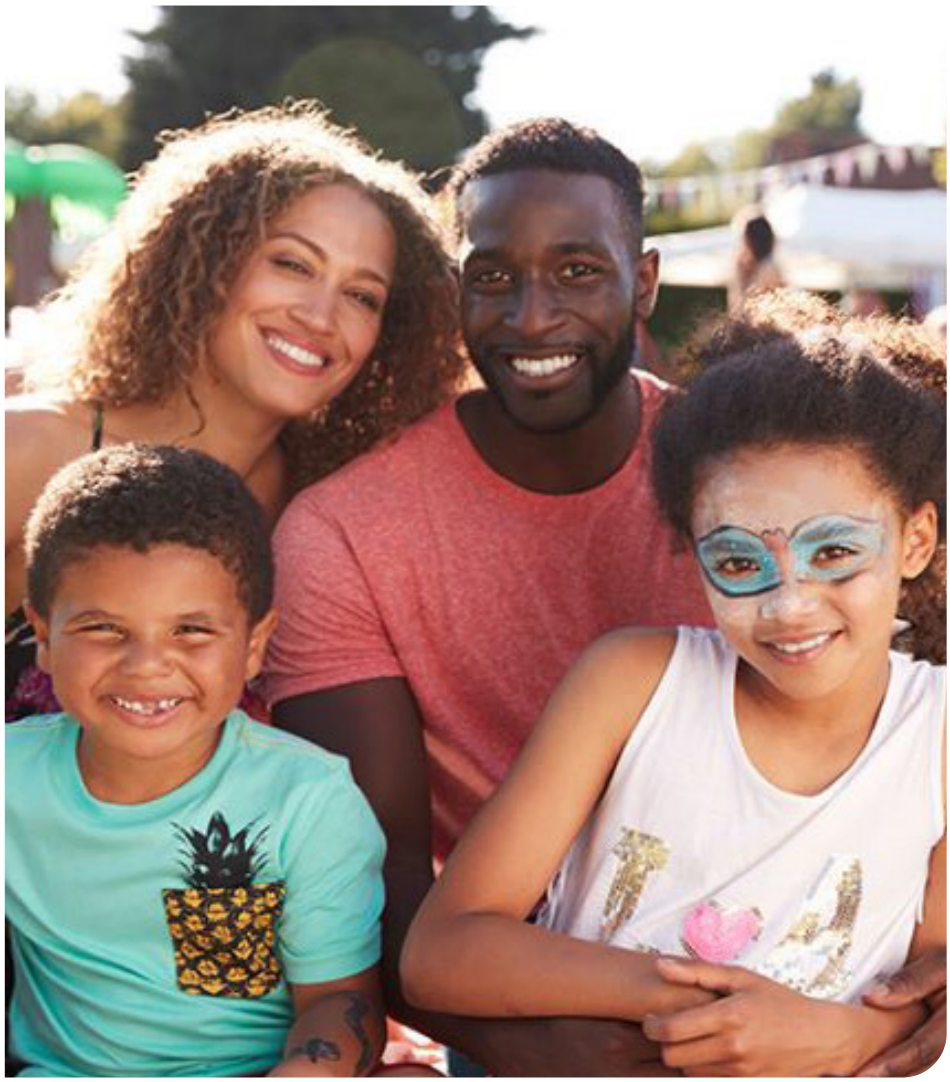
CITY OF RICHMOND



Retirees **Benefits** Guide

2026

CITY OF RICHMOND
Department of Human Resources

DATE: October 13, 2025

TO: All Eligible City Retirees

FROM: HR Benefits and Wellness Division, Human Resources

SUBJECT: RETIRED EMPLOYEES - Benefits Open Enrollment – Calendar Year 2026

Open Enrollment for your 2026 benefits is October 27, 2025 through November 14, 2025
Changes Effective: January 1, 2026

The City of Richmond strives to deliver a comprehensive, high-quality, and affordable benefits program. This document provides information, primarily, regarding our Cigna medical, vision, and dental benefits. To ensure you have the information you need to make informed decisions, please read all communications regarding Open Enrollment and the City's Benefits plans that are available to retirees.

Summary information as well as the most significant changes for the 2026 calendar year are as follows:

MEDICAL PLAN:

- Each year, the City reviews the healthcare spend and trends, claims data and coverage rates. As with all organizations and healthcare in general, the City has seen increases. However, the City has worked diligently to ensure there is minimal impact on our retirees. Retirees will have an overall 6.2% increase to medical premiums in 2026. **Please see pages 10 - 11 of the Retirees Benefits Guide for all plan and premium details.**
- We are pleased to share that the City will continue to offer the same plan options as last year with no change to benefits. Plan 1 offers the lowest premium, and we encourage you to consider this plan when looking at healthcare costs for the upcoming year.
- Those who participated in the annual Healthcare Incentive Initiative will receive an additional credit of $25 per month in City contributions. As in prior years, if you have a spouse on your healthcare plan with Cigna, BOTH you and your spouse must have completed the biometric screening incentive to receive the lower rates for 2026. If only one completed the incentive, you will not receive the lower rates for 2026.

DENTAL PLAN:

- There are no changes to the City of Richmond dental plans in 2026. To view the two plans offered and the dental premiums, **please see page 12 of the Benefits Guide.**

MARATHON HEALTH CLINICS:

- The Marathon Health clinic remains a little to no cost option for those on the City health plan and offers many services including physical therapy, behavioral health, primary care, acute care, immunizations, laboratory services, pharmacy, and more! You can transfer your prescriptions to the pharmacy at the Hioaks clinic and pay no cost for the prescriptions if on the Marathon formulary. **Please see pages 6 - 7 of the Benefits Guide for all details.**

We encourage you to consider all options available to you as you make your decision for healthcare insurance in 2026. Generally, some of your choices are to:

1. Elect the City's retiree medical insurance during Open Enrollment. Complete the enrollment form if you want to change to a different plan or you want to cancel coverage. You will find the enrollment form in this packet. Unless you are making a change, you do not need to complete the enrollment form.
2. Review the City's two medical plans offered to eligible retirees. Review the differences in each plan including the deductible, coinsurance, copays, medication coverage, out-of-pocket maximum, as well as the differences in premiums. The best plan is the one that best fits the needs of you and your covered dependents.
3. Review and/or elect coverage with your new/current employer's medical plan (if applicable).
4. Review and/or elect coverage with your working spouse's medical plan (if applicable).
5. Review and/or elect coverage from the Federal Marketplace/Exchange, which can be accessed by going to the website: www.HealthCare.Gov.
   > HealthCare.Gov has several healthcare providers and plan designs. It does not hurt to compare premiums and you may find that you can purchase similar coverage in the Marketplace at a rate that would be more affordable than the City's early retiree premiums.
   > If you need assistance with this choice, please contact Human Resources Benefits and Wellness Division at **804-646-4700** or the Richmond Retirement System at **804-646-5958.** We can connect you with an expert resource who can provide you with individual help.
   > Note that Open Enrollment for HealthCare.gov runs from November 1 to January 15.

EMPLOYEE ASSISTANCE PROGRAM (EAP):

The City of Richmond will continue to offer an Employee Assistance Program (EAP) at no cost to you. EAP personal advocates will work with you to resolve a number of issues you may be facing. The City works with Cigna to provide unlimited telephonic consultations, and up to six counseling sessions with a counselor in your area. You can reach the EAP by calling **1-877-622-4327** or by going to www.mycigna.com and entering your Employer ID: COR.

OTHER IMPORTANT INFORMATION:

Please read all communications regarding Open Enrollment and your plan options. If you have changes you wish to make for your 2026 medical or dental elections, please make those changes on the enrollment form enclosed. Note that your changes must be received by November 14, 2025.

City of Richmond Retirees

OPEN ENROLLMENT DATES: OCTOBER 27 – NOVEMBER 14, 2025

CHANGES EFFECTIVE JANUARY 1, 2026

WHAT YOU NEED TO KNOW:

- **Open Enrollment Period:** Retirees can make benefit changes for medical and dental during the Open Enrollment period. All changes will be effective January 1, 2026.

- **Medical and Dental:** During the Open Enrollment period, you may enroll, decline, or make changes to your medical and dental plan elections. Your dependents who are currently enrolled may continue coverage if they do not have access to healthcare insurance coverage through their own employer. Retirees wishing to make changes will need to complete the enclosed paper enrollment form or DocuSign form.

- You can learn more about Open Enrollment and your benefits options by doing the following:
  1. Reading the enclosed documents.
  2. Contacting one of these representative with your questions.
     > For the Richmond Retirement System, call **804-646-5958.**
     > For the Human Resources Benefits and Wellness Division, call **804-646-4700,** or email HRBenefits@rva.gov using the subject line of "Open Enrollment."
       - During Open Enrollment, calls will be answered from 8 a.m. to 5 p.m., Monday-Friday, except for the following Holidays: November 4th *(PLEASE VOTE!)* and November 11th *(THANK YOU, VETERANS!)*.
       - **Note:** Because Open Enrollment ends on November 14th, please submit your questions promptly (preferably prior to November 12th) to ensure we are able to answer before Open Enrollment closes.
  3. Be sure to check your email and the Richmond Retirement website frequently to ensure you have the most updated information.

- If you are mailing your enrollment form and/or other documentation, please allow ample time for the postal service to deliver your packet as these documents must be received by November 14, 2025. The mailing address for the Richmond Retirement Department is:

  City of Richmond
  Attn: Richmond Retirement System
  730 E. Broad Street, Suite 900
  Richmond, Virginia 23219

- If you would like to send your documentation electronically, please visit this link: bit.ly/CORRetiree and fill out/sign the secure DocuSign form.

The deadline for this Open Enrollment period is Friday, November 14, 2025. Retirees making changes must have all documents delivered to the Retirement System offices before 5:00 p.m. on November 14, 2025.

HEALTH CARE PROGRAMS – OVERVIEW

CIGNA MEDICAL PLAN

Medical benefits are very important for almost everyone. Our goal is to continue offering the highest quality and most cost-effective health care coverage for our retirees.

Cigna Healthcare will continue to be the City of Richmond's medical plan administrator in 2026. The City has two medical plan choices. Both provide coverage in full for eligible wellness visits and preventive care visits, are open access plans, and provide the same broad network of service providers. They also provide vision and prescription drug benefits.

One of the primary differences in these two plan options is how much you pay in premiums and how much you will pay if/when you receive services (a cost that varies by your usage).

OUT-OF-NETWORK BENEFITS

In both of the plan options, you may receive care from providers outside of the provider network. However, the benefits you receive in the network will be paid at a higher level than those received out of the network.

You can visit Cigna's website for a complete listing of participating providers at www.Cigna.com. Enter your zip code to find a provider in your area.

PRESCRIPTION DRUG BENEFITS

Cigna encourages physicians to prescribe from a published list of prescription drugs (the formulary) which is available by logging on to myCigna.com. Your formulary may not cover all FDA-approved medications; however, it contains a full range of drugs including all of those required under applicable health care laws. You will pay more if you or your doctor chooses a "non-preferred" brand drug. Your physician may work with Cigna to ensure that the medications they prescribe for you are covered by Cigna. Keep in mind, regardless of the type of drug prescribed, all of your prescriptions must be filled at participating pharmacies. If filled by Marathon Health Hioaks clinic, prescription drugs will have no cost if on their formulary.

If you take a "maintenance" drug -- one that you are expected to take for a long period of time -- you may be able to save money by ordering a 90-day supply through the mail, or utilizing the Cigna 90 Now℠ retail pharmacy program, or by receiving the prescription at the Marathon Health pharmacy, if available.

CIGNA VISION PLAN

You automatically receive vision coverage, in partnership with EyeMed, when you choose a medical plan with Cigna. Coverage includes an annual routine eye exam benefit, coverage for eyewear, discounts for eyeglass lens upgrades, and LASIK or PRK laser vision correction.

MARATHON HEALTH CLINICS

Both plans come with access to the Richmond Network Marathon Health Clinics for free (or low cost for Plan 1). The clinics provide primary care services, sick care services, immunizations, laboratory services, a full on-site pharmacy, physical therapy, behavioral health services, and virtual care services, at two convenient locations. Please see page 6 for more details.

HEALTH CLINICS

Marathon Health™

Your healthcare benefit

We're excited to offer those on the medical plan Marathon Health as part of your benefits package as a City of Richmond employee, spouse, and/or dependent. Marathon Health is your complete health partner, covering up to 90% of your health and wellness needs.

Who can use Marathon Health?

Employees, spouses and dependents on any City of Richmond health plan have access to healthcare services.

How do I access healthcare services?

Marathon Health offers both in-person and virtual appointments for your convenience. To schedule an in-person or virtual appointment, call 888-830-6538 or visit the Marathon Health online patient portal or app.

How we're different:

- Care when you need it: With our same-day and next-day appointments for immediate concerns, you can talk to your provider quickly. Physical therapy, behavioral health, and health coaching is available with no referral required!
- Care how you want it: Say goodbye to crowded waiting rooms and rushed appointments. Say hello to seeing your provider for as long (or as short) as you want, in person or from home, thanks to our convenient patient portal/ app.
- Care at the cost you want: Services within the Marathon Health Centers are little to no cost to you!

Marathon Health
@ Downtown Richmond
626 E Broad St., Ste. 100
Richmond, VA 23219
888-830-6538

Hours

Mon.	7 am - 4 pm
Tues.	7 am - 4 pm
Wed.	7 am - 4 pm
Thur.	7 am - 4 pm
Fri.	7 am - 4 pm

Marathon Health
@ Hioaks
7012 Marlowe Rd., Ste. 100
Richmond, VA 23225
888-830-6538

Hours

Mon.	8 am - 5 pm
Tues.	8 am - 5 pm
Wed.	10 am - 7 pm
Thur.	8 am - 5 pm
Fri.	8 am - 5 pm
Sat.	8 am - 12 pm

Marathon Health
@ Hanover
10412 Washington Hwy. Ste. C
Glen Allen, VA 23059
888-830-6538

Hours

Mon.	8 am - 5 pm
Tues.	10 am - 7 pm
Wed.	8 am - 5 pm
Thur.	10 am - 7 pm
Fri.	8 am - 5 pm
Sat.	8 am - 12 pm

Schedule an appointment
Call 888-830-6538
or visit **my.marathon.health**

HEALTH CLINICS continued

Marathon Health

Our services

In-person and virtual care

Marathon Health is your health partner, covering up to 90% of your health and wellness needs.

Switch your prescription to Marathon Health with no cost to you. Have your provider call the Hioaks Pharmacy at **804-538-1698** and have significant savings or even no-cost medications.

Physical therapy is available with no referral needed and at little to no cost to you.

Primary and preventive care

- Annual exams and preventive screenings
- Blood pressure screening
- Biometric screening (height, weight, blood glucose, and cholesterol)
- Condition management (diabetes, heart disease, COPD, and more)
- Mental health services
- Vaccines (Flu, HPV, TDAP, and more)

Immediate & sick care

- Bronchitis
- Common cold and cough
- Constipation
- Diarrhea
- Eye infections
- Headache
- Joint pain
- Nausea and vomiting
- Nosebleed
- Sinus infections
- Skin infections
- Strep throat

Additional services

- **Physical therapy** at Marathon Health@Hioaks (No referral needed)
- **Onsite pharmacy** at Marathon Health@Hioaks (Prescriptions covered in full)
- Virtual and in-person health coaching

Lab services - all no cost

- Basic metabolic panel
- Blood draws and sample collection
- Cholesterol
- Hemoglobin A1c
- Pregnancy test
- Screening for diabetes
- Urinalysis
- *Additional lab tests can also be drawn and sent to an outside lab for processing at no cost*

Schedule an appointment
Call 888-830-6538
or visit **my.marathon.health**

The care you receive by Marathon Health is confidential and protected by state and federal law.

CIGNA MEDICAL PLANS

This is only a summary of benefits. Please refer to your full description of benefits provided by Cigna for complete details. In the event of a discrepancy, the information provided by Cigna will determine how your benefits will be applied.

IN-NETWORK BENEFITS	Plan 1 (High Deductible with HSA)	Plan 2
Annual Deductible* - Individual / Family	$2,000 / $4,000	$750 / $1,500
Out-of-Pocket Limit* - Individual / Family	$4,000 / $8,000	$4,000 / $8,000
Individual in a Family	$4,000	—
Preventive Care		
Adult Preventive Exams and Tests	Covered in full by plan	Covered in full by plan
Mammogram, PAP, PSA Tests	Covered in full by plan	Covered in full by plan
Well Child Care	Covered in full by plan	Covered in full by plan
Coinsurance	10%	20%
Other Services		
Inpatient Hospital (per admission)	Deductible, then 10%	Deductible, then 20% + $500
Outpatient Surgery	Deductible, then 10%	Deductible, then 20% + $300
PCP / Specialist Office Visit	Deductible, then 10%	$25 copay / $50 copay
Lab and X-ray		
Doctor's Office - PCP / Specialist	Deductible, then 10%	$25 copay / $50 copay
Independent Lab / Outpatient Facility	Deductible, then 10%	Deductible, then 20%
Advanced Imaging		
Doctor's Office - PCP / Specialist	Deductible, then 10%	$25 copay / $50 copay
Independent Lab / Outpatient Facility	Deductible, then 10%	Deductible, then 20%
Chiropractic Services (Medical Necessity Review)	Deductible, then 10% (Combined with Rehabilitation)	$25 / $50 copay (30 days)
Short-term Rehabilitation (Physical, Speech, and Occupational Therapy)	Deductible, then 10% (Combined 90 days)	$25 / $50 copay (Combined 60 days)
Marathon Health Physical Therapy Appt.	$25 until ded. is met, then 10%	Covered in full by plan
Maternity Care (Excluding IP Hospital)	Deductible, then 10%	Global Maternity Fee: Deductible, then 20% Office visits in addition to Global Fee: $25 copay / $50 copay
Fertility Services	Authorized benefits are covered based on the place of treatment and the type of service provided.	
Marathon Health Office Visit	$25 until ded. is met, then 10%	Covered in full by plan
Urgent Care	Deductible, then 10%	$50 copay
Emergency Room (Copay waived if admitted)	Deductible, then 10%	$250 copay, then 20%
Transgender-Related Services	Medically necessary care, behavioral health services, hormone replacement therapy, and gender reassignment surgery are covered services under the plans based on the type and place of service, including gender-affirming surgical procedures, hormone therapy, mental health care, and all related medical visits and laboratory services. Note that all applicable benefit limitations, precertification, and medical necessity criteria will still apply.	
Mental Health / Substance Use Disorder		
Inpatient Hospitalization	Deductible, then 10%	Deductible, then 20% + $500
Outpatient Services		
Doctor's Office:	Deductible, then 10%	$25 copay
Marathon Health Behavioral Health Visit	$25 until ded. is met, then 10%	Covered in full by plan
All Other Services:	Deductible, then 10%	Deductible, then 20%
OUT-OF-NETWORK BENEFITS		
Annual Deductible* - Individual / Family	$4,000 / $8,000	$1,500 / $3,000
Out-of-Pocket Limit* - Individual / Family	$13,100 / $26,200	$10,000 / $20,000
Coinsurance	50%	50%

*** Deductible and Out-of-Pocket Limits will RESET each January 1.**

CIGNA PRESCRIPTION DRUG PLAN BENEFITS

You automatically receive prescription drug coverage when you choose a medical plan with Cigna. Please refer to your full description of benefits provided by Cigna for complete details.

IN-NETWORK BENEFITS	Plan 1 (High Deductible with HSA)	Plan 2
Prescription Drugs (The formulary that applies to this program is Cigna's Standard formulary, which is a closed formulary)		
30-Day Retail		
Generic	Deductible, then $10 copay	$10 copay
Preferred Brand	Deductible, then $30 copay	$30 copay
Non-Preferred Brand	Deductible, then $55 copay	$55 copay
Specialty	20% to a maximum of $250	20% to a maximum of $250
90-Day Home Delivery / Retail		
Generic	Deductible, then $10 copay	$10 copay
Preferred Brand	Deductible, then $60 copay	$60 copay
Non-Preferred Brand	Deductible, then $165 copay	$165 copay
Specialty (30-day only)	20% to a maximum of $250	20% to a maximum of $250
Diabetes Test Strips through OneTouch	Covered in full	Covered in full
***Marathon Health Hioaks Pharmacy**	Free	Free

*** Available if on the Marathon Health formulary, separate from Cigna. See page 7 for more information. Refer to page 8 for the deductible amounts.**

CIGNA VISION PLAN BENEFITS

You automatically receive vision coverage when you choose a medical plan with Cigna. Please refer to your full description of benefits provided by Cigna for complete details.

	In-Network	Out-of-Network	Frequency Period*
Exam Copay	$15	NA	12 months
Exam Allowance (once per frequency period)	Covered 100% after copay	Up to $45	12 months
Material Copay	$0	NA	12 months
Eyeglass Lenses Allowances (one pair per frequency period)			
Single Vision	Covered in full	Up to $32	12 months
Bifocal	Covered in full	Up to $55	12 months
Trifocal	Covered in full	Up to $65	12 months
Lenticular	Covered in full	Up to $80	12 months
Contact Lenses Allowances (one pair or single purchase per frequency period)			
Elective	Covered in full	Up to $87	12 months
Therapeutic	Covered in full	Up to $210	12 months
Frame Retail Allowance (one per frequency period)	Covered in full	Up to $55	24 months

*** Your frequency period begins on January 1 (calendar year basis).**

MEDICAL, PRESCRIPTION AND VISION RATES

Your contributions will vary depending upon whether you and your covered spouse have taken and submitted your biometric screening results to Marathon Health. The Healthcare Incentive for 2026 has been closed. The 2026 Healthcare Incentive will be open in early 2026 for 2027 rates. In early summer, check your mail for updates to ensure you receive the discount towards 2027 rates.

CIGNA MEDICAL, PRESCRIPTION AND VISION

ALL ELIGIBLE RETIREES	Total monthly	What COR contributes monthly	What you pay monthly
Plan 1 (HDHP) High Deductible with HSA			
Healthcare Incentive Taken (with Marathon Health)			
10 - 14 Years of Service			
Retiree Only	$1,155.52	$125.00	$1,030.52
Retiree + Child	$1,964.37	$125.00	$1,839.37
Retiree + 1/Retiree + Spouse	$2,311.01	$125.00	$2,186.01
Retiree + Family	$3,081.94	$125.00	$2,956.94
15 - 19 Years of Service			
Retiree Only	$1,155.52	$225.00	$930.52
Retiree + Child	$1,964.37	$225.00	$1,739.37
Retiree + 1/Retiree + Spouse	$2,311.01	$225.00	$2,086.01
Retiree + Family	$3,081.94	$225.00	$2,856.94
20 - 24 Years of Service			
Retiree Only	$1,155.52	$325.00	$830.52
Retiree + Child	$1,964.37	$325.00	$1,639.37
Retiree + 1/Retiree + Spouse	$2,311.01	$325.00	$1,986.01
Retiree + Family	$3,081.94	$325.00	$2,756.94
25+ Years of Service			
Retiree Only	$1,155.52	$425.00	$730.52
Retiree + Child	$1,964.37	$425.00	$1,539.37
Retiree + 1/Retiree + Spouse	$2,311.01	$425.00	$1,886.01
Retiree + Family	$3,081.94	$425.00	$2,656.94
Healthcare Incentive NOT Taken (with Marathon Health)			
Dependent			
Dependent	$1,033.84	$0.00	$1,033.84
Dependent + Family	$2,334.97	$0.00	$2,334.97
10 - 14 Years of Service			
Retiree Only	$1,155.52	$100.00	$1,055.52
Retiree + Child	$1,964.37	$100.00	$1,864.37
Retiree + 1/Retiree + Spouse	$2,311.01	$100.00	$2,211.01
Retiree + Family	$3,081.94	$100.00	$2,981.94
15 - 19 Years of Service			
Retiree Only	$1,155.52	$200.00	$955.52
Retiree + Child	$1,964.37	$200.00	$1,764.37
Retiree + 1/Retiree + Spouse	$2,311.01	$200.00	$2,111.01
Retiree + Family	$3,081.94	$200.00	$2,881.94
20 - 24 Years of Service			
Retiree Only	$1,155.52	$300.00	$855.52
Retiree + Child	$1,964.37	$300.00	$1,664.37
Retiree + 1/Retiree + Spouse	$2,311.01	$300.00	$2,011.01
Retiree + Family	$3,081.94	$300.00	$2,781.94
25+ Years of Service			
Retiree Only	$1,155.52	$400.00	$755.52
Retiree + Child	$1,964.37	$400.00	$1,564.37
Retiree + 1/Retiree + Spouse	$2,311.01	$400.00	$1,911.01
Retiree + Family	$3,081.94	$400.00	$2,681.94

RATES continued

CIGNA MEDICAL, PRESCRIPTION AND VISION

ALL ELIGIBLE RETIREES	Total monthly	What COR contributes monthly	What you pay monthly
Plan 2 (Classic)			
Healthcare Incentive Taken (with Marathon Health)			
10 - 14 Years of Service			
Retiree Only	$1,362.28	$125.00	$1,237.28
Retiree + Child	$2,315.89	$125.00	$2,190.89
Retiree + 1/Retiree + Spouse	$2,724.59	$125.00	$2,599.59
Retiree + Family	$3,686.99	$125.00	$3,561.99
15 - 19 Years of Service			
Retiree Only	$1,362.28	$225.00	$1,137.28
Retiree + Child	$2,315.89	$225.00	$2,090.89
Retiree + 1/Retiree + Spouse	$2,724.59	$225.00	$2,499.59
Retiree + Family	$3,686.99	$225.00	$3,461.99
20 - 24 Years of Service			
Retiree Only	$1,362.28	$325.00	$1,037.28
Retiree + Child	$2,315.89	$325.00	$1,990.89
Retiree + 1/Retiree + Spouse	$2,724.59	$325.00	$2,399.59
Retiree + Family	$3,686.99	$325.00	$3,361.99
25+ Years of Service			
Retiree Only	$1,362.28	$425.00	$937.28
Retiree + Child	$2,315.89	$425.00	$1,890.89
Retiree + 1/Retiree + Spouse	$2,724.59	$425.00	$2,299.59
Retiree + Family	$3,686.99	$425.00	$3,261.99
Healthcare Incentive NOT Taken (with Marathon Health)			
Dependent			
Dependent	$1,244.15	$0.00	$1,244.15
Dependent + Family	$2,671.74	$0.00	$2,671.74
10 - 14 Years of Service			
Retiree Only	$1,362.28	$100.00	$1,262.28
Retiree + Child	$2,315.89	$100.00	$2,215.89
Retiree + 1/Retiree + Spouse	$2,724.59	$100.00	$2,624.59
Retiree + Family	$3,686.99	$100.00	$3,586.99
15 - 19 Years of Service			
Retiree Only	$1,362.28	$200.00	$1,162.28
Retiree + Child	$2,315.89	$200.00	$2,115.89
Retiree + 1/Retiree + Spouse	$2,724.59	$200.00	$2,524.59
Retiree + Family	$3,686.99	$200.00	$3,486.99
20 - 24 Years of Service			
Retiree Only	$1,362.28	$300.00	$1,062.28
Retiree + Child	$2,315.89	$300.00	$2,015.89
Retiree + 1/Retiree + Spouse	$2,724.59	$300.00	$2,424.59
Retiree + Family	$3,686.99	$300.00	$3,386.99
25+ Years of Service			
Retiree Only	$1,362.28	$400.00	$962.28
Retiree + Child	$2,315.89	$400.00	$1,915.89
Retiree + 1/Retiree + Spouse	$2,724.59	$400.00	$2,324.59
Retiree + Family	$3,686.99	$400.00	$3,286.99

DENTAL PLANS

There are two dental plan options the City offers in 2026 — Dental PPO plan (Cigna Total DPPO) and DHMO plan (Dental Care Access plan).

- The Cigna Total DPPO plan allows you to use a dentist from Cigna's DPPO network or to use a provider not in the network. If you use a dentist not in Cigna's DPPO network, you will generally pay more for services.
- The Cigna Dental Care Access plan (DHMO) is similar to a Medical HMO because you must select a dentist who is in the Cigna Dental Care Access network and receive services from that dentist. You will pay fixed copays for any covered dental services provided by a Dental Care Access dentist.

DENTAL PLAN FEATURES	Total DPPO In-network	Total DPPO Out-of-Network	Dental Care Access (Charge may vary based on actual procedure codes)
Annual Deductible - Individual / Family	$50 / $150	$50 / $150	$0
Annual Benefit Maximum	Year 1: $1,500	Year 1: $1,000	—
(Members progress to the next level by using Class I services in the prior year)	Year 2: $1,600	Year 2: $1,100	—
	Year 3: $1,700	Year 3: $1,200	—
	Year 4: $1,800	Year 4: $1,300	—
Separate Office Visit Fee (Regular Hours)	None	None	$5
Class I - Preventive & Diagnostic Care Oral Exams, Cleanings, Routine X-rays, Fluoride Application, Sealants, Space Maintainers (non-orthodontic), Non-Routine X-rays, Emergency Care to Relieve Pain	No charge	No charge	Refer to Cigna Dental Care Patient Charge Schedule
Class II - Basic Restorative Care Fillings, Oral Surgery/Extractions, Surgical Extraction of Wisdom Teeth, Anesthesia, Periodontics, Endodontics (Root Canal Therapy), Relines, Rebases, Adjustments to Dentures, Implants, Repairs – Bridges, Crowns, Inlays, Repairs – Dentures, Brush Biopsy, Stainless Steel/Resin Crowns	Deductible, then 20%	Deductible, then 20%	Refer to Cigna Dental Care Patient Charge Schedule
Class III - Major Restorative Care Crowns, Bridges, and Implants, Dentures (Full & Partial Upper/Lower)	Deductible, then 50%	Deductible, then 50%	Refer to Cigna Dental Care Patient Charge Schedule
Class IV – Orthodontia			
Employee and All Dependents	50%	50%	Refer to Cigna Dental Care Patient Charge Schedule
Lifetime Maximum Benefit	$1,500	$1,500	

Please refer to your full description of benefits provided by Cigna for complete details.

DENTAL CONTRIBUTIONS

2026 CIGNA DENTAL ALL ELIGIBLE RETIREES	Total monthly	What you pay monthly	What you pay bi-weekly
Total DPPO			
Employee Only	$31.83	$31.83	$15.92
Employee + One Child	$52.53	$52.53	$26.67
Employee + Spouse	$65.68	$65.68	$32.84
Employee + Family	$103.65	$103.65	$51.83
Dental Care Access (DHMO)			
Employee Only	$17.94	$17.94	$8.97
Employee + One Child	$29.35	$29.35	$14.68
Employee + Spouse	$36.56	$36.56	$18.28
Employee + Family	$50.05	$50.05	$25.03

Improve Your Quality of Life.

EXPLORE

Assistance Managing Your Health and Healthcare

Cigna, in partnership with the City of Richmond, has many programs and resources available to help you and your dependents manage their healthcare. See below for details.

Cigna OneGuide – Concierge Service to Help with Everything Cigna

Your One Guide representative will help guide you through the complexities and unclear jargon of the health care system, and help you avoid costly missteps. Cigna's One Guide service provides personalized assistance to help you:

- Resolve health care issues, find the right hospitals and other health care providers in your plan's network, get cost estimates, understand your bills and more!

To reach a One Guide representative call: 1-800-Cigna24 or 1-800-244-6224. Access the Cigna One Guide support tool by downloading the myCigna App.

Personal Health Team – Health Coaching, Treatment Decision Support

LIVE personalized support for you and your family to help you manage your health and remove barriers to care. Your health advocate will help you understand your condition, discuss treatment options, remind you to refill your prescription, visit your doctor, or follow-up on other forms of care. They're there to help you learn how to develop healthier habits for a healthier you.

Call to talk with your Health Advocate today, call 1-877-459-6150. Or, visit myCigna.com or the myCigna mobile app for information and self-help resources.

Cigna Pharmacy – Home Delivery – Cigna 90 Now

Cigna Home Delivery Pharmacy is designed for individuals who take prescription medications on a regular basis, such as those used for diabetes or high blood pressure to name a few.

- Fast, convenient delivery of your prescription medications to a location of your choice
- Free refill reminder service will call, text, or email you when it's time to refill prescriptions
- Cigna pharmacists are available 24/7 to answer your medication questions

Call: 1-800-285-4812 to switch your prescription to home delivery.

Make filling a prescription simple. We will request a prescription from your doctor and once we receive it, we will fill your medication and mail it to your home or other location of your choice.

Cigna 90 Now is a pharmacy program designed to allow customers to fill 90-day supplies of medication at any in-network pharmacies contracted to fill for 90-day supplies.

Virtual Care – MDLIVE

Cigna offers virtual doctor's visits through MDLIVE - to help you get the care you need – including most prescriptions - for a wide range of minor conditions. You can connect with a board-certified doctor via video chat or phone, without leaving your home or office. Telehealth visits are covered under the medical plan and billed at the same rate or less than a regular office visit.

- Visits are available in the areas of dermatology, primary care, wellness, and behavioral care.

Create an account on MDLIVEforCigna.com. You can also download the app on your mobile device.

Call MDLIVE at 1-888-726-3171.

Estimate your Costs Tool - Medical or Pharmacy Costs

Did you know that the costs of medical procedures or prescriptions can vary among facilities? Using the Estimate your Cost tool, you can see what your projected cost would be for an upcoming medical procedure as well as compare pricing among in network facilities nearby. Cost estimates are based on your coverage and deductible status and clearly indicate which doctors are in-network to help you make the most of your plan. Medication cost estimates are also available on this tab.

Available on myCigna.com & the mobile app.

Your Health First – Cigna Chronic Condition Support

Your Health First coaches are specially trained to help and provide support for individuals who have a chronic health condition such as asthma, low back pain, depression, diabetes, coronary artery disease and more. If you have a chronic condition, they can help you:

- Make more educated decisions about your health and treatment options
- Create a plan to help improve your health & identify the triggers that affect your condition
- Understand medications and doctor's orders
- Know what to expect if you need to stay in the hospital

Call: 1-855-246-1873 to speak with a coach.

myCigna.com & myCigna Mobile App

myCigna.com and the myCigna Mobile App provide a variety of tools to make managing your health and your health finances easier!

You can access ID cards for your entire family, locate nearby medical facilities, find and compare doctors, and review quality-of-care ratings. Additionally, you can obtain cost estimates for medical procedures at nearby walk-in facilities, compare prescription drug costs across local pharmacies, view health claims, and manage your account and deductible balances.

Go to: myCigna.com, to register and create a User ID & Password.

Download the myCigna App from the Apple or Google Play app stores.

24/7 Nurse Line & Health Information

Not sure if you need to go to the doctor? Have a health concern and need some advice? The 24/7 Nurse Line provides toll-free access to specially trained staff any time of day or night to answer health questions and give guidance with health concerns.

Call: 1-800-564-9286 or 1-800-244-6224.

Behavioral Health

Cigna provides coaching support services with access to behavioral experts with extensive experience. Find a health care professional in the network geared to your needs. Behavioral health challenges can be diverse and complex. Cigna has a broad menu of virtual provider options.

To learn more, visit myCigna.com, Wellness Tab, Mental Health Support. Or call the toll-free number on your ID card.

To access more information scan QR code.

Improve Your Quality of Life.

EXPLORE

Wellness Resources & Support Programs

Whether you need help reducing stress, are feeling motivated to make a change in your life, or need to talk to someone, Cigna and the City of Richmond offers a variety of tools to help support you and your dependents in your total wellness.

Self-paced Lifestyle Management Programs – Weight, Stress & Tobacco

Cigna has partnered with WebMD to provide resources related to improving your overall wellbeing! Whether you want to utilize a tracker to manage your stress level, or learn how to reduce or quit tobacco, these programs could help. Each program is easy to use and available where and when you need it! Want some additional support? Pair a Lifestyle Management Program with the support of health coaching (described below).

Visit myCigna.com, and click under Wellness.

Digital Health Coaching from My Health Assistant

My Health Assistant, in partnership with WebMD, offers online coaching programs for better health and wellness. Some options include Lose Weight; Eat Better; Enjoy Exercise: Feel Happier; Conquer Stress; Quit Tobacco; Manage Diabetes; Manage Heart Disease; Manage Asthma; Manage COPD; and more.

Visit myCigna.com, and click under Wellness, click on Health Assistant.

Healthy Rewards Incentive Program – Cigna Member Discounts

Cigna provides a range of discount programs through its Healthy Rewards Program. The discount savings are offered on wellness products, LASIK Vision correction, fitness memberships at facilities such as Planet Fitness, Crunch, Gold's Gym, and more.

To learn more visit myCigna.com or call 1-800-870-3470.

MotivateMe – Incentives & Rewards Program

MotivateMe allows members to earn rewards for participating in health improvement activities – such as an annual physical, completing a health assessment and/or participating in health coaching. Employees who participate earn rewards!

Go to myCigna.com and view the 'Incentive Spotlight' under Wellness.

Healthy Pregnancies/Healthy Babies

The Cigna maternity management program called Healthy Pregnancies/Healthy Babies is designed to support members throughout pregnancy. Nurses are available over the phone 24/7 to help with everything from morning sickness to maternity benefits. You are also eligible for rewards for participating in the program.

Call to enroll: 1-800-615-2906. MotivateMe Rewards: $150 gift card if you enroll first trimester; $75 gift card if you enroll second trimester. Must complete your postpartum check in to redeem.

Employee Assistance Program (EAP)

EAP personal advocates will work with you and your household members on issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more. A wide range of services are offered, including face-to-face counseling sessions, legal assistance, referrals, and financial consultation. The EAP provides resources for parenting, eldercare, pet care, and more.

Accessing the EAP Code on myCigna.com.
Visit myCigna.com for an EAP code! Click on the EAP landing page, and then 'Visit an EAP Counselor'. There you can generate a code, or call 1-877-662-4327 for assistance - Employer ID: COR.

Connect anytime
Call: 1-877-622-4327.
TTY/TDD users call 711.
Connect through myCigna.com.
Employer ID: COR (for initial registration).

Personal Health Assessment Tool

The Cigna Health Assessment is an online health risk assessment tool that helps you analyze your health status. It takes 15-20 minutes to complete and provides you with a personalized action plan with resources for improving your health.

Find it on myCigna.com, under Wellness.

Diabetes Prevention Program with Omada

Omada is a personalized program that helps members with pre-diabetes lose weight and create healthier habits through one-on-one personal coaching and the tools needed to make long-lasting health changes.

Check to see if you are eligible and join today for $0.
omadahealth.com/richmondgov

Findhelp.org Social Needs Support

Cigna has provided access to a website that can locate community programs, services, and resources available in the Richmond area, like free or low-cost housing, access to food, education, transportation and more. Visit the link on the right to learn more.

Visit cignacommunity.findhelp.com and enter a zip code.

Autism Specialty Care Program

Members with a child diagnosed with an Autism Spectrum Disorder can gain access to a dedicated team of licensed mental health professionals with extensive expertise. The Cigna Autism Specialty Care Program offers support in understanding an Autism Spectrum Disorder (ASD) diagnosis, explaining treatment options covered under the benefits plan, assisting with care coordination, and much more.

You can sign up for the series at Cigna.com/autism.
Or call 1-800-274-7603 and at the prompt, choose "Behavioral Health," and ask for a Autism Case Manager.

Emotional Wellbeing Apps

Prevail is an on-demand coaching and personalized learning program offered through Cigna. Learn how to boost your mood and improve mental health with on-demand coaching, 24/7.

Happify is a free science-based resilience app offered through Cigna. Happify's activities and games are designed to help you overcome life's challenges, and can be accessed at any time.

To learn more, visit myCigna.com then click on the Wellness Tab and Mental Health Support. Or call the toll-free number on your ID card, or visit: iPrevail.com/cigna and happify.com/cigna.

Heartbeat Health

It can take up to one month for a new patient to get an in-person appointment with a cardiologist. Heartbeat Health is a virtual-first cardiology clinic that treats cardiovascular conditions to proactively identify, treat, and manage moderate cardiovascular risk.

- Supports atrial fibrillation, vascular disease, heart failure, and post-acute care.
- Available in all 50 states and partners with customers to identify, treat, and manage moderate cardiovascular risk.
- Average 48 hours wait time for a virtual visit.
- Reduces cost and minimizes facility fees.
- Clinically guided treatment, medication management, and recommendations.

To learn more, visit myCigna.com. Go to Find Care & Costs, select Reason for Visit, search for Heart and select Virtual Care Services.

To access more information scan QR code.

RICHMOND RETIREMENT SYSTEM DEFINED BENEFIT EARLY RETIREE HEALTHCARE PROGRAM

City of Richmond employees who apply to retire as active members in the Richmond Retirement System Defined Benefit Plan, or the Enhanced Defined Benefit Plan, are eligible for health insurance benefits at retirement.

The following conditions apply for calendar year 2026:

- The employee must be at least age 55 (but not over age 65) and must have worked for the City of Richmond for at least 10 years with the last 5 years consecutive.
- Coverage must be elected with the City within 30 days of the departure of employment. The decision to reject coverage or to drop coverage at a later date is a final, permanent decision.
- Enrolling dependents in coverage with the City is permitted if the dependents have no access to healthcare through their own employer. Dependents must be enrolled at the time of the employee's departure of employment. The decision to reject dependent coverage or to drop coverage at a later date is a final, permanent decision.
- Choices include Plan 1 High Deductible Plan or Plan 2 (no Plan 3 option).

Contribution from the City toward the premium is based on years of service. In 2026, the City's contribution toward coverage in the City's health insurance benefits is as follows:

- For 10-14 years of service - $100 per month
- For 15-19 years of service - $200 per month
- For 20-24 years of service - $300 per month
- For 25 years of service or more - $400 per month

Note: Those who participate in the annual health assessment will receive an additional credit of $25 per month in City contributions.

For additional terms and conditions, contact Human Resources or the Richmond Retirement System.

IMPORTANT LEGAL NOTICES

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. You may be entitled to additional benefits as mandated by state law.

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact HR Benefits and Wellness Division.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

HR Benefits and Wellness
HRBenefits@rva.gov
804-646-4700

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

IMPORTANT LEGAL NOTICES continued

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

IMPORTANT LEGAL NOTICES continued

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor or contracted care manager, Marathon Health, for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

OTHER INSTRUCTIONS FOR NOTICE

- January 1, 2026
- HR Benefits and Wellness Division, HRBenefits@rva.gov, 804-646-4700

IMPORTANT LEGAL NOTICES continued

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

IMPORTANT NOTICE FROM CITY OF RICHMOND ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Richmond and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of Richmond coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Richmond coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of Richmond 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 Benefits and Wellness Division at 804-646-4700 for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Richmond changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IMPORTANT LEGAL NOTICES continued

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:	City of Richmond Human Resources
Contact--Position/Office:	HR Benefits and Wellness Division
Address:	900 East Broad Street, Room 902, Richmond, Virginia 23219
Phone Number:	804-646-4700 (office)

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

IMPORTANT LEGAL NOTICES continued

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
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

IMPORTANT LEGAL NOTICES continued

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov | Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
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/
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.

OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT LEGAL NOTICES continued

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2027)

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

IMPORTANT LEGAL NOTICES continued

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Richmond	4. Employer Identification Number (EIN) 54-6001556	
5. Employer address 900 East Broad Street	6. Employer phone number 804-646-7000	
7. City Richmond	8. State VA	9. ZIP code 23219
10. Who can we contact about employee health coverage at this job? Department of Human Resources		
11. Phone number (if different from above) 804-646-4700	12. Email address HRBenefits@rva.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All Employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Full-Time and Part-Time Permanent Employees
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouses and dependent children under the age of 26.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis). if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs coverage by the plan is no less than 60 percent of such costs (Section 36B©(2)(ii) of the Internal Revenue Code of 1986.)

GLOSSARY

After-tax
Paying for benefits after federal, state and FICA taxes are deducted.

Beneficiary
The person(s) you designate to receive payment from your insurance policies when you die.

Capitation
A set dollar limit that you or your employer pay to a health maintenance organization (HMO), regardless of how much you use (or don't use) the services offered by the health maintenance provider.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, federal legislation that allows you and/or your dependents to continue to purchase health insurance for up to 18 months if you lose your job or your employer-sponsored coverage is otherwise terminated. Dependents may be eligible for COBRA coverage for up to 36 months in the event of your divorce or death, or when your child reaches the limiting age under the plan. COBRA is available to employees who work for an employer with 20 or more employees.

Coinsurance
The percentage of covered medical costs you pay.

Coordination of Benefits
An arrangement in health insurance to discourage multiple payments for the same claim under two or more policies. When a person is covered by two or more group health insurance plans, one plan becomes the *primary* plan and the other plan(s) the secondary plan(s).

Copayment
The flat fee that you pay per unit for certain medical services.

Covered Expenses
Charges eligible for plan payment

Deductible
A fixed dollar amount of covered medical charges you must pay before the plan pays for additional covered services. Your deductible depends on the medical plan you select.

Dependent
In the Medical and Dental plans, a dependent is defined as:

(1) your lawful spouse; and

(2) any child of yours who is:

- less than 26 years old.
- 26 or more years old, unmarried, and primarily supported by you and incapable of self- sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian. Benefits for a dependent child will continue until the last day of the month in which the limiting age is reached.

Anyone who is eligible as an employee will not be considered as a dependent spouse. A child under age 26 may be covered as either an employee or as a dependent child. You cannot be covered as an employee while also covered as a dependent of an employee. No one may be considered as a dependent of more than one employee.

Disability
Inability to work because of a medically certified illness or injury.

Explanation of Benefits (EOB)
The insurance company's written explanation regarding a claim, showing what they paid and what you must pay.

Generic Drug
Once a company's patent on a brand-name prescription drug has expired, other drug companies are allowed to sell the same drug under a generic label. Generic drugs are less expensive than brand-name drugs.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
A legislative act that allows people to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also mandates the use of 1) standards for the electronic exchange of health care data; 2) national identification systems for health care patients, providers, payers, and employers; and 3) measures to protect the security and privacy of personally identifiable health care.

Health Maintenance Organization (HMO)
Health maintenance organizations represent "pre-paid" or "capitated" insurance plans in which doctors are paid a fixed monthly fee for services instead of separate fees for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided. Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design.

GLOSSARY continued

Inpatient Care
Medical care you receive after you're formally admitted into a hospital.

Life Insurance
Term life insurance that pays a death benefit to your beneficiary if you die. There is no cash surrender value.

LTD (Long-term Disability)
A disability due to a medically-certified illness or injury that lasts for more than 180 days.

Medicaid
A health insurance program for low-income individuals who cannot otherwise afford Medicare or other commercial health insurance plans. Medicaid is funded in part by the government and by the state where the enrollee lives.

Medicare
The federal health insurance program created to provide health coverage for Americans aged 65 and older and later expanded to cover younger people who have permanent disabilities or who have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS).

Network
A group of health care providers, including doctors, hospitals and specialists who join together to provide care at specially negotiated rates.

Non-duplication of Benefits
A coordinated payment method used when more than one health insurance plan is paying benefits.

Orthodontia
Dental services which straighten teeth and correct bite.

Out-of-Pocket Maximum
The maximum dollar amount you pay out of your pocket in a calendar year for covered expenses, including deductibles and coinsurance. The plan pays 100% of covered expenses after the limit is reached (up to the plan's maximum benefit) for the remainder of the year.

Patient Protection and Affordable Care Act (PPACA), also known as Affordable Care Act (ACA)
The health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will continue to be rolled out over the next four years.

Point of Service (POS)
A point of service (POS) plan is a combination of an HMO and a PPO. It has a network that functions like an HMO. A member may also choose to use out-of-network providers; however, the member will pay more when using out-of-network providers.

Pre-tax
A contribution for benefits that is taken from your pay before federal, state, and FICA taxes are withheld. Note that Tax Sheltered Annuities are pre-tax on federal and state only.

Preferred Provider Organization (PPO)
A preferred provider organization (PPO) is a managed care organization of health providers who contract with an insurer to provide health insurance coverage. Services by these providers are discounted substantially. If a member uses a physician outside the PPO plan, they typically pay more for the medical care.

Preventive Care
Services that maintain good health and prevent disease - such as check-ups and early detection screenings.

Primary Care Physician (PCP)
The doctor responsible for directing all your medical care and referrals.

Specialty Drugs
Specialty drugs or specialty pharmaceuticals are a type of pharmaceuticals that are classified as high- cost, high-complexity and/or high-touch. Specialty drugs may also include biologics that are injected or infused. This class of drug is not typically available from a retail pharmacy.

Spouse
A person who is legally married to an employee under the laws of the state in which the employee resides.

CITY OF RICHMOND – RETIREE
MEDICAL & DENTAL ENROLLMENT / CHANGE FORM

RETIREE INFORMATION: List your information on with line with the X. Be sure to include all information requested.

Name	Last	First	M.I.	Social Security #
X -				

Personal Email	Home and Work Phone Numbers	Date of Birth	Date of Hire
X –			

Mailing Address
X –

Complete this section: Enrollment Type (List: Change or Open Enrollment)	Effective Date of Add/Change/Cancellation (MM/DD/YYYY)
X –	

Type of Change (List: Add Dependent(s), Cancel Dependent(s), or Cancel Employee)	Last Date of Coverage (if cancelling) (MM/DD/YYYY)
X –	

Choice of Medical Benefit (List one: Plan 1 (High Deductible), Plan 2, or Decline Medical)	Choice of Dental Benefit (List one: Dental Care Access-DHMO, DPPO, or Decline Dental)
X –	

II. RETIREE and DEPENDENT INFORMATION: If you are adding, changing or canceling coverage, list below the full name, the Social Security Number, the gender, the date of birth, the coverage selection of Medical, Dental or Both, and list if you are adding coverage or canceling coverage. List yourself on the first line. Specify if dependent's last name is different than yours.

Last	First	M.I.	SSN#	Gender	Date of Birth	List: Medical, Dental or Both	List: Add or Cancel
X - (Retiree)							
X - (Spouse)							
X - (Dependent)							
X - (Dependent)							
X - (Dependent)							

Note: If additional dependents cannot fit in this section, please attach the information on a separate page.

III. RETIREE SIGNATURE and DATE:

X -

HR Internal Use Only: _____
Benefits Team Member Accepted/Entered – Sign and date

900 East Broad Street

Room 902

Richmond, Virginia 23219

This Benefits Enrollment Guide is intended as a summary of your retiree benefits. Please refer to the booklets and/or contracts that apply to each of the plans for complete details. In the event of a discrepancy in benefits, the full plan booklets and contracts will determine how your benefits will be applied.