

Benefit Coordinators Corporation (BCC)
Two Robinson Plaza
Suite 200
Pittsburgh, PA 15205



FIRST NAME LAST NAME
ADDRESS LINE 1
ADDRESS LINE
CITY, STATE ZIP CODE

RE: 2026 RETIREE BENEFITS OPEN ENROLLMENT NOTIFICATION

Date: 09/15/2025

Group: City of Newport Beach Retirees

BCC Group Number: CONB

Welcome to your 2026 Retiree Benefits Open Enrollment!

- This is your annual opportunity to review, update, or maintain your benefit elections.
- Changes outside this period can only be made if you experience a qualified life event.
- New elections take effect January 1, 2026.
- All plan materials, rate sheets, and the Retiree Election Form can be accessed online:
 - <https://www.newportbeachca.gov/government/departments/human-resources/virtual-health-fair/retiree-corner>
- The City's monthly contribution for the CalPERS health plan is increasing from \$158 to \$162.

ENROLLMENT REFERENCE GUIDE

Action	CalPERS Medical Plan	Delta Dental Dental Plan	VSP Vision Plan
Enroll	Contact CalPERS directly	Individuals who are not currently enrolled, including those who have withdrawn, are not eligible for new enrollment or re-enrollment	
Change / Cancel	Contact CalPERS directly	Record selection on enclosed election form	
No Changes	Record selection on enclosed election form		

**RETIREES ARE TO SUBMIT THE RETIREE ELECTION FORM BY MAIL OR EMAIL
BY OCTOBER 10, 2025.**

If you have any questions, please contact
BCC's Customer Service Call Center 800-685-6100.



City of Newport Beach Retiree Election Form

THIS FORM MUST BE SUBMITTED TO BCC BY OCTOBER 10, 2025.

PERSONAL INFORMATION

Name (First, M., Last)	
Birthdate	
Mailing Address	
Email Address	
Phone Number	
Marital Status	

Please check the appropriate box below to confirm your enrollment status for 2026.

CalPERS MEDICAL ELECTION

<input type="checkbox"/>	I am electing CalPERS health coverage for 2026. <i>Note below on how to contact CalPERS by the deadline.</i>
<input type="checkbox"/>	I am declining CalPERS health coverage for 2026. <i>Note below on how to contact CalPERS by the deadline.</i>
<input type="checkbox"/>	I have no changes for my current medical election.

CONTACT CALPERS

If you are making any changes or enrolling in a CalPERS medical plan, you must log into your myCalPERS account at www.mycalpers.ca.gov or call 888-225-7377 by Friday, October 10, 2025.

VSP PPO VISION ELECTION

If currently enrolled in vision, please make your coverage selection.	RETIREE ONLY	RETIREE + ONE	RETIREE + TWO OR MORE	NO CHANGES	DECLINE VISION COVERAGE <small>(Cancellations are final; re-enrollment not allowed)</small>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DELTA DENTAL ELECTION					
If currently enrolled in dental, please select the coverage for your desired dental plan.	RETIREE ONLY	RETIREE + ONE	RETIREE + TWO OR MORE	NO CHANGES	DECLINE DENTAL COVERAGE (Cancellations are final; re-enrollment not allowed)
Delta Dental DHMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Dental PPO (High)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Dental PPO (Low)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VISION AND DENTAL DEPENDENT INFORMATION

For each dependent, check Add or Delete, and select which coverage applies. Use additional sheets of paper if necessary.

Dependent	Relationship (e.g. spouse, child)	SSN	DOB	Action
Name:				<input type="checkbox"/> Add vision <input type="checkbox"/> Add dental <input type="checkbox"/> Delete vision <input type="checkbox"/> Delete dental
Name:				<input type="checkbox"/> Add vision <input type="checkbox"/> Add dental <input type="checkbox"/> Delete vision <input type="checkbox"/> Delete dental
Name:				<input type="checkbox"/> Add vision <input type="checkbox"/> Add dental <input type="checkbox"/> Delete vision <input type="checkbox"/> Delete dental

RETIREE AUTHORIZATION

I verify that all the information I supplied and/or corrected on this enrollment form is true and complete to the best of my knowledge. I understand that by signing this form, I am making a binding election for my benefits for the 2026 calendar year. I further understand that I may not change my benefit elections unless the changes are a result of and consistent with a qualified status change. I understand that if I experience a qualified status change, I must notify CalPERS and BCC within 60 days of the status change.

Please submit completed and signed forms to BCC by October 10, 2025, via mail or email.

- Mail: Benefit Coordinators Corporation, Two Robinson Plaza, Suite 200, Pittsburgh, PA, 15205
- Email: customersupport@benxcel.com | Phone: 800-685-6100

Retiree Signature: _____

Date: _____