2024-25
BENEFIT GUIDE
RETIREES

Table of Contents

Important Notice

Folsom Cordova Unified School District has made every attempt to ensure the accuracy of the information described in this benefit guide. This guide is not an official plan document and does not provide a complete description of your benefit plans. Any discrepancy between this guide and the insurance contracts, summary plan descriptions (SPDs) or any other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to those documents. Folsom Cordova Unified School District reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible retirees and Folsom Cordova Unified School District share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with Folsom Cordova Unified School District. (4/2024)

Welcome

As a District retiree, you have access to a comprehensive quality benefits package that offers flexibility and security.

Open Enrollment is the perfect time to evaluate the best benefit options for you and your family. Be sure to consider factors like plan costs and what type of services you anticipate needing for the upcoming year.

Open Enrollment for 2024-25 coverage – **your one chance to make changes to your benefits[1]** – begins May 10 and will remain open until June 14. The benefits you choose will become effective on the first day of the next plan year which is September 1, 2024. **If you don't actively participate in Open Enrollment, your medical plan elections may change. If you are an Early Retiree and enrolled in any medical plan other than the High Option Copay plans, your election will move to the new Nonstop Health plans with each carrier.**

You must participate in Open Enrollment if you wish to do any of the following (employees retiring this year, please see Page 5):

- Currently Enrolled Participants: You may change plans and or add/drop dependents.
- Not enrolled but Receiving Cash-In-Lieu: The District requires recertification annually. Please refer to the email that was sent out with directions on how to re-certify. You may re-certify to continue your cash-in-lieu or you may enroll in one of the District's medical plans. NO LATE SUBMISSIONS ACCEPTED.
- Not-Enrolled and Not Receiving Cash-In-Lieu: Not eligible to enroll in the District's medical plans.
- **For Dental and Vision, you would not be eligible to enroll in the dental and/or vision plans if you are not currently enrolled (unless waived).**

Please take the time to read and understand this guide so you can choose what is best for you. If after reading this guide you need more information, please contact the District's Benefits Office:

Jenyn Warren (Retirees)	**Annie DeLand (A-L)**	**Liz Ely (M-Z)**
(916) 294-9000 x104382	(916) 294-9000 x104381	(916) 294-9000 x104383
jwarren@fcusd.org	adeland@fcusd.org	lely@fcusd.org

You may also contact the Support Center at (844) 714-0147 or click here to Schedule an Appointment.

Benefit summaries and forms for all plans included in this guide can be found on the District's website under Staff/Benefits.

[1]You can change your coverage during the year if you experience a "Qualified Status Change," including but not limited to gain or loss of coverage, marriage, registered domestic partnership, divorce, birth or adoption of a child or death of spouse or child. You have up to 30 days from the date of the event to notify the District, request a change and submit the necessary paperwork. Failure to do so within the 30-day window will forfeit your right to make a mid-year change. You will need to wait until the District's next open enrollment period to make any enrollment changes.

OPEN ENROLLMENT May 10, 2024 – June 14, 2024

For coverage September 1, 2024 through August 31, 2025

You should have received an email on May 9th, regarding a SPECIAL presentation just for Retirees. It will be at the ESC in the Boardroom on Tuesday, May 14 from 10am-11am. This year the Benefits Fair will be held at the District in the Boardroom on Tuesday, May 14, 2024, from 1:00pm-6:00pm. Plan-specific information is available on **https://www.fcusd.org** under Staff/Benefits. If you need assistance, please email your Benefits Specialist or contact the Employee Support Center.

Welcome

All forms are due to the District's Benefit Office no later than 4:30 pm on Friday, June 14th, 2024.

IMPORTANT NOTICE IF YOU ARE ENROLLED IN MEDICAL AND YOU OR YOUR SPOUSE TURNS 65

The District will attempt to send a courtesy reminder to retirees, prior to turning 65, indicating they will be losing their District contribution and must change medical enrollments. Once you terminate your medical coverage, you cannot re-enroll at a later date. If your spouse will be turning 65, please notify the District. You and your spouse must enroll in Medicare Parts A & B when eligible and requires a change to the medical plans.

What Is Changing

All medical premiums have increased for the 2024-25 plan year effective September 1, 2024.

New Program - Nonstop Health!

If you are an Early Retiree, the medical plans will be changing as outlined below. Some of the medical plans will be eliminated and new plans will be available through Nonstop Health, who is partnering with the medical carriers Kaiser, SHP and WHA. Please see table below showing the current plans versus the new plans and review page 8 and page 9 for additional information.

If you are Over 65, there is no change to the medical plans. **Please note that WHA's Medicare Advantage plan will not be offered after January 1, 2025. Please take this information into consideration when making your enrollment decisions. You will have an opportunity to change plans closer to the January 1 end date.**

*The Traditional Copay plans ARE NOT part of Nonstop. Therefore, they do not receive the Visa card.

Old Plan	New Plan
Kaiser Traditional $20 copay	*Kaiser $20 Copay Plan
Kaiser $20 Hospital Copay	Kaiser Nonstop
Kaiser HDHP High	
Kaiser HDHP Low	
Sutter Health Plus HMO ML67	*SHP $15 Copay Plan
Sutter Health HDHP High	SHP Nonstop
Sutter Health HDHP Low	
Western Health Adv Premier 0/20/0	*WHA $20 Copay Plan
Western Health Adv 0/20/500	WHA Nonstop
Western Health Adv HDHP 1800/0/0 Prime	

Kaiser Permanente

The Kaiser Mid HMO as well as the High and Low HDHP (HSA) plans will no longer be offered for the new plan year. These three plans are being replaced with the new Kaiser Nonstop plan. This plan will have benefits of up to $5.500 for Individual coverage and $11,000 for Family coverage through Nonstop Health for medical services and prescriptions. You will not have to pay for any services (with the exception of the Emergency Room Copay of $100) until you have reached your deductible. YYou will then have copays and coinsurance until you reach your out-of-pocket maximums of $7,000 for Individual coverage and $14,000 for Family coverage. Max out-of-pocket of $1,500 or $3,000 on the back-end after all the $5,500 or $11,000 has been spent. Once the out-of-pocket maximum is reached, Kaiser will pay 100% for any remaining services for the rest of the calendar year.

Sutter Health Plan (SHP)

The SHP High and Low HDHP (HSA) plans will no longer be offered for the new plan year. These two plans are being replaced with the new SHP Nonstop Plan. This plan will have benefits of up to $6,500 for Individual coverage and $13,000 for Family coverage through Nonstop Health for medical services and prescriptions. You will not have to pay for any services (with the exception of the Emergency Room Copay of $100) as these amounts cover the full out-of-pocket expenses through the calendar year.

Western Health Advantage (WHA)

The WHA HDHP (HSA) plan will no longer be offered for the new plan year. This plan is being replaced with the new WHA Nonstop plan. This plan will have benefits of up to $5,500 for Individual coverage and $11,000 for Family coverage through Nonstop Health for medical services and prescriptions. You will not have to pay for any services (with the exception of the Emergency Room Copay of $100) as these amounts cover the full out-of-pocket expenses through the calendar year.

Health Net is no longer being offered due to low enrollment. If you are currently enrolled in the Health Net plan, you will need to choose another plan.

VSP Vision Plan

The frame allowance will increase to $160.

HSA Plan Ending September 1, 2024

HSA Plans will no longer be offered due to the implementation of the new Nonstop Health Plan. As a result, you will no longer be able to contribute pre-tax dollars to your HSA account. However, you will still be allowed to use the HSA Bank account funds that you have accumulated to pay for eligible medical, dental, and vision out of pocket costs.

Your HSA bank account will automatically rollover to an individual account. If you have $2,500 or more in your account, there will not be a monthly service charge. If you have less than $2,500 in your account, you will be charged a monthly service fee. You will receive a letter directly from Health equity during the month of September 2024 with further instructions.

Eligibility & Enrollment

ELIGIBILITY

Current retirees and their eligible dependents can participate in the District's benefits. Certain restrictions apply. Eligible dependents include:

- Legal Spouse or California state-registered domestic partner[1]
- Child(ren) up to age 26 – your natural or adopted children, stepchildren and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order
- Child(ren) of any age if he or she is incapable of self-support due to mental or physical disability

PROOF OF DEPENDENT ELIGIBILITY

If you are adding dependents for the first time to your medical, dental or vision plans, you must provide proof of eligibility by providing supporting documentation as listed below:

1. **If adding a spouse – marriage certificate**
2. **If adding a domestic partner – Registered Domestic Partnership Certificate from the State of California**
3. **If adding a child – birth certificate or final legal adoption decree.**

If your dependent becomes ineligible for coverage during the year, you must contact the District's Benefits Office within 30 days. Failure to provide notification may lead to forfeiture of any COBRA rights and premiums paid for your dependents. If you do not take action within the 30-day window, you will have to wait until the District's next open enrollment period to make a change.

ENROLLMENT

Why it is Important to Participate in Open Enrollment

All eligible retirees are requested to actively participate in this open enrollment. If you are enrolled in one of our medical plans currently, you will need to review the changes being made to these plans. For Early Retirees, please take the time to review your current benefits as the mid HMO options and the HDHP options are being replaced by the Nonstop Plans. For retirees over 65, the WHA Medicare Advantage Plan will be ending on January 1, 2025. Also, it is an opportunity for you to review your demographic information, current health benefit elections and dependent enrollments as well as understand any changes which may have occurred with the benefit plans and/or premium changes.

How to Participate / Enroll

Eligible retirees can enroll or make changes by completing the required enrollment/change form found on the District's Benefits website. Completed forms should be emailed to **Jenyn Warren, jwarren@fcusd.org, or mailed to ESC, no later than 4:30 pm on Friday, June 14, 2024.** You will need to select a new plan if you are on the Health Net Seniority Plus plan as it will no longer be offered as of September 1, 2024. If you are enrolled in the WHA Medicare Advantage Plan, please consider changing your plan to one of the other options since this plan will be terminating on January 1, 2025.

[1]Due to federal and state tax regulations, benefits provided to domestic partners are generally taxable. Additionally, any premium contributions made by the District on behalf of your domestic partner are generally considered taxable income to you. Contact the District's Benefits Office if you believe your domestic partner is exempt from federal or state taxes.

Eligibility & Enrollment

Retiree Policies

Retirement eligible employees are subject to different rules than active employees. Below is a summary of the District's retiree policies.

Medical - Eligible Active employees:

Continue current plan

- 12-month employees will become a retiree first of the month following date of retirement
- 10-month and 11-month employees will become a retiree effective September 1, 2024
- May enroll or change plans and/or levels at retirement (i.e., retirement is a qualifying event)
- Move from cash-in-lieu to enrollment in a medical plan upon retirement
- Move from enrollment in medical plan to cash-in-lieu if proof of other group coverage is provided

Dental and/or Vision

Eligible Active employees have these benefits available:

Continue current plan

- 12-month employees will become a retiree first of the month following date of retirement
- 10-month and 11-month employees will become a retiree effective September 1, 2024
- May enroll, change plans and/or levels at retirement (i.e., retirement is a qualifying life event)
- Retiree will be responsible for full cost of monthly premiums once enrolled as a retiree

Retirees enrolled in a medical plan may only change plans during open enrollment unless they move out of the service area or are aging into Medicare. If you believe you have an eligible mid-year qualifying life event, please contact the benefits department for review.

Retirees receiving cash-in-lieu may enroll in a medical plan during open enrollment OR if they experience a loss of coverage (i.e., spouse loses insurance, change in employment, etc.) If a retiree who is out of area and receiving cash-in-lieu moves back into the service area, they may enroll in a medical plan through the District if they lose their other coverage (i.e., out of state coverage). Notification to the benefits department must be completed within 30 days of the event.

Nonstop Health - Early Retirees Only

Introducing Nonstop Health! We are excited to provide you and your family with a high-quality, affordable alternative healthcare program that significantly or fully pays your out-of-pocket expenses.

What is Nonstop Health?

Nonstop Health is a type of healthcare program that allows organizations to fund a portion of their employees' healthcare premiums and out-of-pocket expenses (e.g. deductibles, copays, and coinsurance) while also saving on premium expenses annually. The Nonstop Health program is a compliant health plan that is paired with a medical expense reimbursement plan (MERP) – and provides you, the member, with a Visa card to help pay for in-network, covered medical expenses, up to the allowed amount of:

- **WHA:** $5,500 for individual plans and $11,000 for family plans. You are only responsible for your monthly premiums.
- **Kaiser:** $5,500 for individual plans and $11,000 for family plans. You could be responsible on the back-end for a maximum of $1,500 or $3,000 in calendar year out-of pocket expenses.
- **Sutter Health:** $6,500 for individual plans and $13,000 for family plans. You are only responsible for your monthly premiums.

With Non-Stop Health, you will receive two Visa cards in the mail after you enroll.

How does it work?

Nonstop Health wraps around your health insurance plan, giving you a preloaded Nonstop Visa card to help pay for covered services and prescriptions received at carrier-approved providers and facilities.

1 Present your **CARRIER CARD** to the front desk so they can apply service costs to your deductible and/or out-of-pocket maximum.

2 Pay for covered services and prescriptions with your **NONSTOP HEALTH VISA CARD**

3 If/when you receive a bill with a remaining balance, pay for those expenses with your **NONSTOP HEALTH VISA CARD**
(note: an Explanation of Benefits (EOB) is not a bill)

* "Covered" means the expense is applied toward your medical plans in-network deductible and out-of-pocket maximum.

All services must be covered under your medical plan and all providers/facilities must be in-network!

TIP: When possible, have your providers office bill the insurance first, and only pay the minimum necessary at the time of service. This will reduce the need for refunds and keep funds available on your card.

Nonstop Health - Early Retirees Only (continued)

WHAT NONSTOP HEALTH DOES AND DOESN'T COVER

Qualifying costs for Nonstop Health include:

- Carrier-approved, covered medical services
- Visits to providers and pharmacies that are considered in-network for your medical plan
- Medications/prescriptions that are covered under your medical plan

Typically, non-qualifying costs include:

- Dental services, unless covered under your medical plan
- Vision services, unless covered under your medical plan
- Over-the-counter medication, vitamins or supplements
- At-home COVID-19 tests or testing done at non-carrier approved testing sites
- Alternative care (chiropractic , acupuncture, massage) not approved by your carrier
- Mental health services not approved by your carrier
- Charges incurred at non-qualifying vendors, such as Amazon, Massage Envy, Warby Parker, Smile Direct Club, etc.
- Talkspace and Betterhelp, unless considered a covered vendor by your insurance

WHAT SHOULD I DO WITH EACH CARD?

Sutter/WHA/Kaiser ID CARD	NONSTOP VISA CARD
	
Your ID card comes from Sutter/WHA/Kaiser, and includes information relevant to the medical plan. You must present your ID card from Sutter/WHA/Kaiser during every doctor visit and for prescription purchases. This is important to ensure that Sutter/WHA/Kaiser is apprised of the charge and properly credits your services toward your in-network deductible/out-of-pocket maximum.	The Nonstop Visa card comes from Nonstop and can be used to pay for in-network, Sutter/WHA/Kaiser-approved medical services and prescriptions, up to the allowed amount for your plan. You cannot use the Nonstop Visa card to purchase over-the-counter drugs. You will receive two Nonstop Visa cards, both in your name. If you need additional cards, call us at **877-626-6057**. We recommend that you do NOT set up a PIN as this will only allow you to use the card as a debit card and not a credit card.

Medical Contributions - Early Retirees

The monthly amounts shown below do not include the district's contribution, if any. Please refer to your letter for your district contribution.

2024-2025 EARLY RETIREE CONTRIBUTIONS			
Kaiser	**Retiree**	**Retiree + One Dependent**	**Retiree + Family**
Kaiser $20 Copay	$1,639.38	$3,278.76	$4,639.44
Kaiser Nonstop	$1,105.38	$2,166.97	$3,108.88
Sutter Health Plan	**Retiree**	**Retiree + One Dependent**	**Retiree + Family**
SHP $15 Copay	$1,341.00	$2,682.20	$3,795.60
SHP Nonstop	$960.70	$1,893.60	$2,696.10
Western Health Advantage	**Retiree**	**Retiree + One Dependent**	**Retiree + Family**
WHA $20 Copay	$830.17	$1,660.36	$2,490.53
WHA Nonstop	$708.00	$1,368.00	$2,068.00

Medical & Prescription Drug Benefits - Early Retirees

When choosing your plan, consider your budget, your preferences, your health and your covered dependents' health. The information below is a summary of coverage only. For more detailed benefit information, visit the District's benefits website.

	Kaiser $20 Copay Employee Pays
Calendar Year Deductible	
Individual Coverage	None
Individual within a family	None
Family Coverage	None
Calendar Year Out-of-Pocket Maximum	
Individual Coverage	$1,500
Individual within a family	$1,500
Family Coverage	$3,000
Physician Services	
Physician/Specialist Office Visits	$20 per visit
Telehealth Visits	No charge
Preventive Care	No charge
Other Services	
Room & Board Hospital Inpatient (semi-private)	No charge
Outpatient Surgery	$20 per procedure
Basic X-ray and Lab	No charge
Emergency Room Services (copay waived if admitted)	$100 copay
Urgent Care Services	$20 copay
Ambulance Services	No charge
Chiropractic Care (20 visits per calendar year)	$15 copay (visits combined with acupuncture)
Acupuncture (20 visits per calendar year)	$15 copay (visits combined with chiropractic)
Prescription Drugs	
Retail (30-day supply)	$10 Generic / $30 Brand
Mail Order (100-day supply)	$20 Generic / $60 Brand
Specialty (30-day supply)	$100 copay

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

Medical & Prescription Drug Benefits - Early Retirees

	Kaiser Nonstop		
	Health Plan Benefits	**Nonstop Pays**	**Employee Pays**
Calendar Year Deductible			
Individual Coverage	$5,500	$5,500	$0
Individual within a family	$5,500	$5,500	$0
Family Coverage	$11,000	$11,000	$0
Calendar Year Out-of-Pocket Maximum			
	Includes Deductible	**Includes Deductible**	**After Deductible**
Individual Coverage	$7,000	$5,500	$1,500
Individual within a family	$7,000	$5,500	$1,500
Family Coverage	$14,000	$11,000	$3,000
Physician Services			
Physician/Specialist Office Visits	$50 copay	In-network medical services covered in full up to deductible - $5,500 individual coverage and $11,000 family coverage	$50 Copay after deductible
Telehealth Visits	No charge		$0
Preventive Care	No charge deductible waived		$0
Other Services			
Room & Board Hospital Inpatient (semi-private)	40% coinsurance after deductible	In-network medical services covered in full up to deductible - $5,500 individual coverage and $11,000 family coverage	40% coinsurance after deductible
Outpatient Surgery	40% coinsurance after deductible		40% coinsurance after deductible
Basic X-ray and Lab	40% coinsurance after deductible		40% coinsurance after deductible
Emergency Room Services (copay waived if admitted)	40% coinsurance after deductible		$100 copay, then 40% coinsurance after deductible*
Urgent Care Services	$50 copay after deductible		$50 copay after deductible
Ambulance Services	40% coinsurance after deductible		40% coinsurance after deductible
Chiropractic Care (20 visits per calendar year)	$15 copay after deductible		$15 copay after deductible (visits combined with acupuncture)
Acupuncture (20 visits per calendar year)	$15 copay after deductible		$15 copay after deductible (visits combined with acupuncture)
Prescription Drugs			
Retail (30-day supply)	$15 Generic (up to 30 day supply) 40% Brand, not to exceed $100 after deductible (up to a 100-day supply)	In-network prescriptions covered in full up to deductible - $5,500 individual coverage and $11,000 family coverage	$15 Generic (up to 30 day supply) 40% Brand, not to exceed $100 (up to a 100-day supply) after deductible
Mail Order (100-day supply)	$30 Generic 40% Brand, not to exceed $100 after deductible		$30 Generic 40% Brand, not to exceed $100 after deductible
Specialty (30-day supply)	40% coinsurance, not to exceed $250 after deductible		40% coinsurance, not to exceed $250 after deductible

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

* $100 copay is due per emergency room visit unless you are admitted into the hospital, regardless of Nonstop Visa card balance.

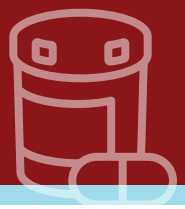
Medical & Prescription Drug Benefits - Early Retirees

When choosing your plan, consider your budget, your preferences, your health and your covered dependents' health. The information below is a summary of coverage only. For more detailed benefit information, visit the District's benefits website.

	SHP $15 Copay Employee Pays
Calendar Year Deductible	
Individual Coverage	None
Individual within a family	None
Family Coverage	None
Calendar Year Out-of-Pocket Maximum	
Individual Coverage	$1,500
Individual within a family	$1,500
Family Coverage	$3,000
Physician Services	
Physician/Specialist Office Visits	$15 copay
Telehealth Visits	$5 copay
Preventive Care	No charge
Other Services	
Room & Board Hospital Inpatient (semi-private)	No charge
Outpatient Surgery	$15 per procedure
Basic X-ray and Lab	No charge
Emergency Room Services (copay waived if admitted)	$35 per visit
Urgent Care Services	$15 per visit
Ambulance Services	No charge
Chiropractic Care (20 visits per calendar year)	$15 copay (visits combined with acupuncture)
Acupuncture (20 visits per calendar year)	$15 copay (visits combined with chiropractic)
Prescription Drugs	
Retail (30-day supply)	$10 Tier 1 $20 Tier 2 $35 Tier 3
Mail Order (100-day supply)	$20 Tier 1 $40 Tier 2 $70 Tier 3
Specialty (30-day supply)	20% up to $100 max copay

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

Medical & Prescription Drug Benefits - Early Retirees



	SHP Nonstop		
	Health Plan Benefits	**Nonstop Pays**	**Employee Pays**
Calendar Year Deductible			
Individual Coverage	$5,500	$5,500	$0
Individual within a family	$5,500	$5,500	$0
Family Coverage	$11,000	$11,000	$0
Calendar Year Out-of-Pocket Maximum			
	Includes Deductible	**Includes Deductible**	
Individual Coverage	$6,500	$6,500	$0
Individual within a family	$6,500	$6,500	$0
Family Coverage	$13,000	$13,000	$0
Physician Services			
Physician/Specialist Office Visits	$50 copay deductible waived	In-network, eligible medical services covered in full	$0
Telehealth Visits	$25 copay after deductible		$0
Preventive Care	No charge deductible waived		$0
Other Services			
Room & Board Hospital Inpatient (semi-private)	30% after deductible	In-network, eligible medical services covered in full	$0
Outpatient Surgery	30% after deductible		$0
Basic X-ray and Lab	Lab: $10 copay X-Ray: $50 copay (ded. waived) Preventive: No charge (ded. waived)		$0
Emergency Room Services (copay waived if admitted)	$150 copay after deductible		$100
Urgent Care Services	$50 copay deductible waived		$0
Ambulance Services	$150 copay after deductible		$0
Chiropractic Care (20 visits per calendar year)	$15 copay (visits combined with acupuncture) after deductible		$0
Acupuncture (20 visits per calendar year)	$15 copay (visits combined with chiropractic) after deductible		$0
Prescription Drugs			
Retail (30-day supply)	$10 Tier 1 $30 Tier 2 $60 Tier 3 deductible waived	In-network eligible prescriptions covered in full	$0
Mail Order (100-day supply)	$20 Tier 1 $60 Tier 2 $120 Tier 3 deductible waived		$0
Specialty (30-day supply)	30% up to $250 max copay deductible waived		$0

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

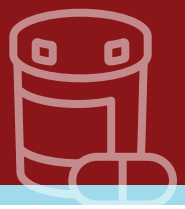
Medical & Prescription Drug Benefits - Early Retirees

When choosing your plan, consider your budget, your preferences, your health and your covered dependents' health. The information below is a summary of coverage only. For more detailed benefit information, visit the District's benefits website.

	WHA $20 Copay Employee Pays
Calendar Year Deductible	
Individual Coverage	None
Individual within a family	None
Family Coverage	None
Calendar Year Out-of-Pocket Maximum	
Individual Coverage	$1,500
Individual within a family	$1,500
Family Coverage	$2,500
Physician Services	
Physician/Specialist Office Visits	$20 copay
Telehealth Visits	$20 copay
Preventive Care	No charge
Other Services	
Room & Board Hospital Inpatient (semi-private)	No charge
Outpatient Surgery	Office: $20 copay; Facility: $100 copay
Basic X-ray and Lab	No charge
Emergency Room Services (copay waived if admitted)	$100 per visit
Urgent Care Services	$35 per visit / $25 per virtual
Ambulance Services	No charge
Chiropractic Care (20 visits per calendar year)	$15 copay up to 20 visits per calendar year combined with acupucture
Acupuncture (20 visits per calendar year)	$15 copay up to 20 visits per calendar year combined with chiropractic
Prescription Drugs	
Retail (30-day supply)	$10 Tier 1 $30 Tier 2 $50 Tier 3
Mail Order (90-day supply)	$25 Tier 1 $75 Tier 2 $125 Tier 3
Specialty (30-day supply)	20% up to $100 max copay

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

Medical & Prescription Drug Benefits - Early Retirees



	WHA Nonstop		
	Health Plan Benefits	**Nonstop Pays**	**Employee Pays**
Calendar Year Deductible			
Individual Coverage	$5,500	$5,500	$0
Individual within a family	$5,500	$5,500	$0
Family Coverage	$11,000	$11,000	$0
Calendar Year Out-of-Pocket Maximum			
Individual Coverage	$5,500	$5,500	$0
Individual within a family	$5,500	$5,500	$0
Family Coverage	$11,000	$11,000	$0
Physician Services			
Physician/Specialist Office Visits	No charge deductible waived	All in-network, eligible medical services covered in full	$0
Telehealth Visits	No charge after deductible		$0
Preventive Care	No charge deductible waived		$0
Other Services			
Room & Board Hospital Inpatient (semi-private)	No charge after deductible	All in-network, eligible medical services covered in full	$0
Outpatient Surgery	No charge after deductible		$0
Basic X-ray and Lab	No charge after deductible		$0
Emergency Room Services (copay waived if admitted)	No charge after deductible		$100
Urgent Care Services	No charge after deductible		$0
Ambulance Services	No charge after deductible		$0
Chiropractic Care (20 visits per calendar year)	No charge after deductible		$0
Acupuncture (20 visits per calendar year)	No charge after deductible		$0
Prescription Drugs			
Retail (30-day supply)	No charge after deductible	All in-network eligible prescriptions covered in full	$0
Mail Order (90-day supply)	No charge after deductible		$0
Specialty (30-day supply)	No charge after deductible		$0

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

RETIREES OVER 65

The District offers retirees over 65 the following Medicare Supplement/Medicare Advantage plans:

- Kaiser Senior Advantage – High Option
- Kaiser Senior Advantage – Low Option
- WHA Medicare Advantage (only available till January 1, 2025)
- The Hartford Medicare Supplement

Benefit summaries for these plans are available **Benefits/Medicare**.

The premiums listed below are the total monthly premiums. Your rates may vary.

TOTAL MONTHLY PREMIUMS	Kaiser Senior Advantage – High Option	Kaiser Senior Advantage – Low Option	WHA Medicare Advantage	The Hartford Medicare Supplement
Retiree Only	$271.00	$251.55	$249.84	$623.69
Retiree + Spouse	$524.00	$503.10	$499.68	$1,247.38

PLEASE NOTE: If you are currently enrolled in Health Net Seniority Plus, please select a new option through Kaiser or The Hartford during open enrollment to continue your coverage for the new plan year.

- Health Net Seniority Plus will no longer be offered as of September 1, 2024, due to low participation.
- WHA Medicare Advantage will no longer be offered as of January 1, 2025 due to carrier eliminating plan.

The Hartford: Plan servicing and administration for retiree medical coverage, underwritten by The Hartford, is done through Bay Bridge Administrators LLC, contact for assistance at **(800) 275-2147** or by emailing retireehealth@bbadmin.com. If you have Medical Claim questions, call: WebTPA **(844) 380-4555** for prescription questions, call ExpressScripts Rx **(888) 345-2560** or Caremark **(800) 966-5772**.

CHIROPRACTIC AND ACUPUNCTURE SERVICES

The medical carrier's contract with outside vendors for their chiropractic and acupuncture benefits. You must receive covered services from a participating provider. You can search for participating providers by utilizing the list below.

More information can be found on the District's benefits website at https://www.fcusd.org.

Carrier	Vendor	Phone	Website
Kaiser	American Specialty Health (ASH)	**(800) 678-9133**	https://www.ashlink.com/ash/kp
SHP	Optum Health	**(800) 428-6337**	https://www.myoptumhealthphysicalhealthofca.com
WHA	Landmark Healthplan	**(800) 298-4875**	https://www.lhp-ca.com

Dental Benefits & Rates

ENROLLED RETIREES ONLY:

Your dental benefits are provided by Delta Dental and available to you and your eligible dependents.

There are two plans - **DeltaCare HMO** and **Delta Dental PPO**. More information can be found at District's benefits website at **https://www.fcusd.org**.

DeltaCare DHMO - This plan is similar to a medical HMO as you must select a contracting dentist or dental group to provide all of your dental care. This plan has a very limited network of specific providers to choose from. You must initiate your dental care through your assigned provider. There are no benefits payable if you do not use your assigned provider. You can search for an in-network provider at **www.deltadentalins.com** and select DeltaCare USA network. DeltaCare DHMO is only available in CA. If you transfer from the Delta Dental PPO plan to this plan and later return to the PPO, your incentive level will reset to 70%. If you move out of the service area, you may change to the Delta Dental PPO.

Delta Dental PPO (Incentive Plan) - New plan members begin with a 70% benefit for the majority of services. A continuing retiree or new retiree currently enrolled will maintain their incentive level. If a member has one claim in the calendar year, the benefit will increase 10% the following January 1 up to 100%. Each member within a family has their own incentive level, and a member will maintain their benefit level as long as they remain on the PPO plan. This plan allows you to visit any licensed dentist; however, you receive advantages such as claims submission and lower out-of-pocket expenses when choosing a network dentist. You can search for a provider by visiting **www.deltadentalins.com**. You receive the best discounts when utilizing PPO dentists.

Dental Benefits & Rates

Key Features	DeltaCare[1]	DELTA DENTAL PPO	
		PPO Network	Premier Network & Out-of-Network
Employee Monthly Premiums (based on pay periods)			
Retiree Only	$20.59	$65.42	
Retiree + One Dependent	$37.82	$124.29	
Retiree + Family	$55.95	$189.71	
Calendar Year Maximum *Per Person*	None	$2,200	$2,000
Calendar Year Deductible	None	None	None
Benefits & Covered Services (You Pay)			
Diagnostic & Preventive *Exams, cleanings and x-rays*	Various copays apply	30% - 0%	30% - 0%
Basic Services *Fillings, sealants and posterior composites*	Various copays apply	30% - 0%	30% - 0%
Endodontics *Root canals*	Various copays apply	30% - 0%	30% - 0%
Periodontics *Gum treatment*	Various copays apply	30% - 0%	30% - 0%
Oral Surgery	Various copays apply	30% - 0%	30% - 0%
Major Services *Crowns, inlays, onlays and cast restorations*	Various copays apply	30% - 0%	30% - 0%
Prosthodontics *Bridges, dentures and implants*	Various copays apply	50%	50%
Orthodontia Services (You Pay)			
Orthodontics *(children and adults)*	Various copays apply	Not covered	Not covered

[1]A detailed copay list can be found on the District's benefits website.

Vision Benefits & Rates

ENROLLED RETIREES ONLY: Coverage is through **VSP**. To find a contracted VSP provider, visit **www.vsp.com**, select FIND A DOCTOR, and choose the **Advantage network**.

Retirees pay the total monthly premium and can continue coverage as long as they continue payment. Once coverage is terminated for any reason, coverage cannot be reinstated at a later date.

Key Features	VSP PPO	
	In-Network	Out-of-Network Reimbursement
Retiree Only	$11.51	
Retiree + One Dependent	$23.02	
Retiree + Family	$37.06	
Exam (once every 12 months)		
WellVision Exam	$5 copay	Up to $45
Contact Lens Exam	Copay not to exceed $50	Deducted from materials allowance
First Service – Glasses OR Contact Lenses (once every 12 months)		
Lenses		
Single Vision Lenses	$0 copay	Up to $31
Bifocal Lenses	$0 copay	Up to $50
Trifocal Lenses	$0 copay	Up to $60
Standard Progressive Lenses	$0 copay	Up to $50
Premium Progressive Lenses	$95 - $175 copay	Up to $50
Lens Enhancements		
Anti-reflecting Coating	$41 copay	Cost of enhancement
Photochromic/Transition Adaptive Lenses	$70 copay	Cost of enhancement
Scratch Resistant Coating	$17 copay	Cost of enhancement
Polycarbonate for Adults	$31 copay	Cost of enhancement
Frames		
Standard Frames	$160 allowance	Up to $50
Featured Frames	$210 allowance	Up to $50
Costco, Walmart and Sam's Club	$90 allowance	Up to $50
Contact Lenses		
Cosmetic	$150 allowance	Up to $125
Medically Necessary	$0 copay	Up to $210

Vision Benefits & Rates (continued)

Key Features	VSP PPO	
	In-Network	Out-of-Network Reimbursement
Second Service – Glasses OR Contact Lenses (once every 12 months)		
Materials Copay	$50 copay	$50 copay
Lenses		
Single Vision Lenses	$0 copay	Up to $31
Bifocal Lenses	$0 copay	Up to $50
Trifocal Lenses	$0 copay	Up to $60
Standard Progressive Lenses	$0 copay	Up to $50
Premium Progressive Lenses	$95 - $175 copay	Up to $50
Lens Enhancements		
Anti-reflecting Coating	$41 copay	Cost of enhancement
Photochromic/Transition Adaptive Lenses	$70 copay	Cost of enhancement
Scratch Resistant Coating	$17 copay	Cost of enhancement
Polycarbonate for Adults	$31 copay	Cost of enhancement
Frames		
Standard Frames	$160 allowance	Up to $50
Featured Frames	$210 allowance	Up to $50
Costco, Walmart and Sam's Club	$90 allowance	Up to $50
Contact Lenses		
Cosmetic	$400 allowance	Up to $125
Medically Necessary	$0 copay	Up to $210
Primary Eyecare Benefit		
Office Visit Copay	$20 copay	Not covered

Value Added Vision Benefits

- **Primary Eyecare Benefit ($20 copay):** The Primary Eyecare Benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions that produce ocular or vision symptoms. A member can seek care from their VSP provider versus their medical primary care physician by visiting **www.vsp.com**.
- **Glasses and Sunglasses:** Get 20% off additional glasses and/or non-prescription sunglasses from any VSP doctor within 12 months of your last WellVision Exam. More information can be found at **www.vsp.com**.
- **Laser Vision Correction:** Receive an average of 15% off the regular price or 5% off the promotional price of laser vision correction. Discounts only apply to contracted facilities. Visit www.vsp.com for more details.
- **Retinal Screening:** Members pay no more than a $39 copay on routine retinal screenings as an enhancement to the WellVision Exam.
- **TruHearing:** You can save up to 60% on a pair of digital hearing aids and savings on batteries for you and your extending family members. For more information, visit **www.truhearing.com/vsp**.

ESSENTIAL TERMS

Before reviewing your benefit choices for this year, here is a refresher on some key health insurance vocabulary that will help you better understand your options:

Premium	The amount of money that is paid for your health insurance every month. The District pays a portion of this amount, and you pay the rest.
Deductible	The amount of money you need to pay out-of-pocket before your insurance begins contributing money for your health care costs. The exception to this are preventive services. These services are covered at no charge and are not subject to the deductible. Deductibles are tracked on a calendar year (January 1 – December 31) not the District's plan year, September 1 through August 31.
Network	A group of doctors, hospitals, labs, and other providers that your health insurance carrier contracts with so you can make visits at a pre-negotiated (and often discounted) rate.
Health Savings Account (HSA)	A personal bank account that can be used to pay for qualified health care expenses. You can only contribute money to this account if you are enrolled in one of the District's High Deductible Health Plans (HDHPs) and not enrolled in Medicare.
Copayment (Copay)	A predetermined dollar amount you pay for visits to the doctor, prescriptions, and other health care (as specified by your plan).
Coinsurance	The percentage you pay for the cost of covered health care services. For example, if the coinsurance under your plan is 20%, you would pay 20% of the cost of the service and your insurance would pay the remaining 80%.
Out-of-Pocket Maximum	The cap on your out-of-pocket costs for the calendar year (January 1 – December 31). Once you have reached this amount, your plan will cover 100% of your qualified medical expenses for the remainder of the calendar year.

Key Contacts

Contact	Phone Number	Website/Email	Plan/Group ID
Kaiser – Medical Kaiser $20 Copay Plan Kaiser Nonstop	**(800) 464-4000** **(800) 777-1370**	**www.kp.org**	032170
SHP – Medical	**(855) 315-5800**	**www.sutterhealthplus.org**	78103
WHA – Medical	**(888) 563-2250**	**www.westernhealth.com**	11875
Nonstop Health	**(877) 626-6057**	**members.nonstophealth.com**	N/A
Hartford – Medical **(Bay Bridge Administrators)**	**(800) 275-2147**	**retireehealth@bbadmin.com**	N/A
DeltaCare – Dental	**(800) 422-4234**	**www.deltadentalins.com**	71691-0047
Delta Dental – Dental	**(866) 499-3002**	**www.deltadentalins.com**	7006-0109
VSP – Vision	**(800) 877-7195**	**www.vsp.com**	30091469
HealthEquity/Wageworks **Retiree Billing**	**(877) 864-9546**	**www.mybenefits.wageworks.com**	N/A
Benefits Office **Jenyn Warren**	**(916) 294-9000 x104382**	**jwarren@fcusd.org**	N/A

MEDICARE PART D CREDITABLE COVERAGE NOTICE

This Notice applies only if:

1. **You and/or your dependent(s) are enrolled in a Folsom Cordova Unified School District medical plan; and,**
2. **You are eligible for Medicare.**

If this does not apply to you, you may ignore this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage with Folsom Cordova Unified School District and 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 employer 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 employer 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. **Folsom Cordova Unified School District has determined that the prescription drug coverage offered under the Folsom Cordova Unified School District plan(s) through Kaiser, Sutter Health Plus (SHP), and Western Health Advantage (WHA) plan(s) are, 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 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 creditable prescription drug coverage during the upcoming calendar year 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 Employer Coverage If You Decide to Join A Medicare Drug Plan?

Your health plan coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your employer coverage for the upcoming calendar year, be aware that you and your dependents may not be eligible to receive health and prescription drug benefits in the future.

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

Annual Notices (continued)

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 Employer 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 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:

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**).

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).

May 1, 2024
Folsom Cordova Unified School District
1965 Birkmont Drive
Rancho Cordova, CA 95742

Annie DeLand (Employee last names A-L)
(916) 294-9000 x104381

Liz Ely (Employee last names M-Z)
(916) 294-9000 x104380

Jenyn Warren (Employee last names M-Z & Retirees)
(916) 294-9000 x104382

SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. The District offers a variety of health coverage options and choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available for your medical plan which summarizes important information about your health coverage options. The SBC and a Uniform Glossary are available on the District's benefits website. A paper copy is also available, free of charge, by emailing the District's Employee Benefits Office.

PATIENT PROTECTION NOTICE

Your health plan may require or allow for the designation of a primary care provider. If so, 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, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate one for you.

You do not need prior authorization from the health plan 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 information on how to select a primary care provider, a list of participating primary care providers, or a list of health care professionals who specialize in obstetrics or gynecology, contact your health plan.

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

If an eligible employee declines enrollment in a group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within **30** days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within **30** days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible retirees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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, contact your health plan.

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 **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 January 31, 2024. Contact your state for more information on eligibility –

To see if any other states have added a premium assistance program since January 31, 2024, 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

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

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program:
http://myakhipp.com | 1-866-251-4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp | 1-916-445-8322
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64:
http://www.in.gov/fssa/hip | 1-877-438-4479
All other Medicaid:
https://www.in.gov/medicaid | 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 1-800-338-8366
Hawki: http://dhs.iowa.gov/Hawki | 1-800-257-8563
HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
1-888-346-9562

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

Annual Notices (continued)

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

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

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

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

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
1-800-657-3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
1-573-751-2005

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

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

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

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
1-603-271-5218
HIPP program toll free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid | 1-609-631-2392
CHIP: http://www.njfamilycare.org/Default.aspx | 1-800-701-0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid
1-800-541-2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov | 1-919-855-4100

NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare
1-844-854-4825

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

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

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

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

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

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

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov
CHIP: http://health.utah.gov/chip | 1-877-543-7669

VERMONT – Medicaid
http://www.greenmountaincare.org | 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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: 1-800-432-5924 **CHIP:** 1-800-432-5924

WASHINGTON – Medicaid
https://www.hca.wa.gov | 1-800-562-3022

WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms
http://mywvhipp.com
Medicaid: 1-304-558-1700
CHIP Toll-free: 1-855-MyWVHIPP (1-855-699- 8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
1-800-251-1269

FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT ENROLLMENT/CHANGE FORM (**RETIREES-** if 65+request Medicare Enrollment form)

❑ New Retiree Enrollment ❑ Open Enrollment	❑ Change of Status	Retirement Date: _____
❑ Certificated ❑ Classified ❑ MGMT/CONF		
Change: ❑Add Dependent ❑ Marriage/Divorce ❑ Name Change ❑ Change of Address ❑ Loss of Other Coverage ❑ Remove Dependent ❑Other (Please Specify): _____		Effective Date: _____ Qualifying Event: _____ Qualifying Event Date: _____

GENERAL INFORMATION & ELECTIONS

1. RETIREE INFORMATION

Last Name:	First Name:	DOB:	❑ Male ❑ Female	Telephone No. ( )
Street Address:		City:	State:	Zip Code:
Home Email Address:				

2. RETIREE & FAMILY INFORMATION – Please list yourself and all eligible member to be enrolled

		Last Name	First Name	Age	Date of Birth (MM/DD/YYYY)	Social Security	Please indicate a coverage election for you and your Dependents		
							MEDICAL	DENTAL ❑ PPO ❑ DHMO	VISION
Self							❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
❑Spouse ❑Registered Domestic Partner	❑ Male ❑ Female						❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Child	❑ Male ❑ Female						❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Child	❑ Male ❑ Female						❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

3. MEDICAL PLAN ELECTION

HEALTH PLAN CARRIER	HEALTH PLAN ADDITIONAL INFORMATION				PLAN SELECTION
Kaiser Permanente					
PREVIOUS KAISER MEMBER? ❑ SELF ❑ SPOUSE ❑ CHILD(REN) IF YES, EMPLOYEE MEDICAL RECORD NUMBER: _____	IF YES, MEDICAL RECORD NUMBER Spouse: _____ Child: _____ Child: _____				❑ Kaiser $20 Copay ❑ Kaiser Nonstop
Sutter Health Plan	**Dependent HMO PROVIDER INFORMATION**				
Employee HMO PROVIDER INFORMATION: PRIMARY PHYSICIAN: PROVIDER ID #: PRIMARY CARE PHYSICIAN MEDICAL GROUP: EXISTING PAITENT: ❑ YES ❑ NO	PCP NAME Spouse: _____ Child: _____ Child: _____	MEDICAL GROUP Spouse: _____ Child: _____ Child: _____	PROVIDER # Spouse: _____ Child: _____ Child: _____	EXISTING PATIENT ❑ YES ❑ NO ❑ YES ❑ NO ❑ YES ❑ NO	❑ SHP $20 Copay ❑ SHP Nonstop
WESTERN HEALTH ADVANTAGE	**Dependent HMO PROVIDER INFORMATION**				
Employee HMO PROVIDER INFORMATION: PRIMARY PHYSICIAN: PROVIDER ID #: PRIMARY CARE PHYSICIAN MEDICAL GROUP: EXISTING PAITENT: ❑ YES ❑ NO	PCP NAME Spouse: _____ Child: _____ Child: _____	MEDICAL GROUP Spouse: _____ Child: _____ Child: _____	PROVIDER # Spouse: _____ Child: _____ Child: _____	EXISTING PATIENT ❑ YES ❑ NO ❑ YES ❑ NO ❑ YES ❑ NO	❑ WHA $20 Copay ❑ WHA Nonstop

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature Required for Kaiser Permanente Plan Date

*Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

****

Sutter Health Plus Member Agreement

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and Combined Evidence of Coverage and Disclosure Form, upon completion and execution of this Enrollment Form.

BINDING ARBITRATION

Sutter Health Plus (SHP) handles and resolves Member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and Combined Evidence of Coverage and Disclosure Form.

Employee Signature: _____ Date: _____ Required for Sutter Health Plus Plan

****

WHA Disclosures

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Employee signature: _____ Date: _____

BENEFIT INFORMATION

Information regarding the benefits offered can be found on the District's benefits website at:
https://pcms.plansource.com
Username: FCUSDEmployee
Password: benefits (lower case)

You may also contact the Benefits Help Desk at (877) 374-2151 or csr@epicbrokers.com

FCUSD's Retiree Billing Administrator, **HealthEquity|WageWorks,** is where all your premium payments will be directed:

HealthEquity|WageWorks Customer Service (877) 722-2667 or www.healthequity.com/wageworks

AUTHORIZATION

The purpose of this agreement is to authorize the election of eligible benefits, which may be necessary to purchase the benefits elected. By signing below, I authorize my information to be sent to HeatlhEquity/WageWorks for billing of monthly premiums.

I have read, understood, and agree to the provisions set out on this form. Furthermore, I declare that the information I have completed on this enrollment form is complete and true. I understand that it is the basis on which coverage may be issued under the plan.

_____	_____	_____
Retiree Printed Name	Retiree Signature	Date


FOLSOM CORDOVA
UNIFIED SCHOOL DISTRICT