2026-2027
BENEFITS GUIDE



Retirees

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Important Notice

Folsom Cordova Unified School District has made every attempt to ensure the accuracy of the information described in this enrollment 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. Any examples, such as infographics provided in this guide are purely illustrative in nature, and actual plan costs and coverage will differ based on coverage selected. 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.

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 retiree benefit options for you and your family. Be sure to consider important factors like a plan's network, services you may need for the upcoming year and plan costs. Open Enrollment is **your annual chance to make changes to your benefits**[1].

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: You may change plans and or add/drop dependents.

- **Not enrolled but Receiving Cash-In-Lieu:** The District requires annual recertification to continue cash-in-lieu or to enroll in a medical plan, refer to the email that was sent out with directions. 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:** Not eligible to enroll in the dental or vision plans if you are not currently enrolled (unless waived).

OPEN ENROLLMENT

May 1, 2026 - June 5, 2026

For coverage September 1, 2026 through August 31, 2027

2026 Benefit Fair
District Boardroom
Tuesday, May 5, 2026
10:00 am - 6:00 pm

Plan-specific information is available on **www.fcusd.org** under Departments/Benefits.

Open Enrollment Assistance

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, benefit summaries and forms can be found on the District's website under Departments/Benefits.

You may also contact the **District's Benefits Office:**

Madison Alman (Retirees) (916) 294-9000 x104384 **malman@fcusd.org**	**Annie DeLand (A-L)** (916) 294-9000 x104381 **adeland@fcusd.org**	**Liz Ely (M-Z)** (916) 294-9000 x104383 **lely@fcusd.org**	**Jenyn Warren** (916) 294-9000 x104382 **jwarren@fcusd.org**

[1] You can change your coverage during the year if you experience a "Qualifying Life Event" 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.

All forms are due to the District's Benefit Office no later than 4:30 pm on Friday, June 5, 2026.

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.

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 that is paid for your health insurance each month. The District pays a portion of the cost and you pay the rest.
Deductible	The amount you pay out-of-pocket before the insurance begins contributing money to your healthcare costs (except for preventive care that is covered at 100%). 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 the plan contracts with so you can get services at a pre-negotiated (discounted) rate.
Copayment (Copay)	A predetermined amount you pay for visits to the doctor, prescriptions, and other health care services.
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 most you will pay out-of-pocket each year for covered expenses. Once you have reached the out-of-pocket maximum, the health plan pays 100% for covered expenses for the rest of the calendar year.
Waiver of Premium	If you are under age 60, become disabled and are no longer able to work, your premium payments may be waived during this period of disability.
Portability/Conversion	If you retire, reduce your hours (and are no longer eligible for benefits) or leave the District, you can take this coverage with you by electing either Portability or Conversion coverage. You will be provided additional information upon your ineligibility for the District's coverage.

KAISER PLANS UPDATE

The Kaiser copay plan will be going away starting September 1, 2026, but the Kaiser High Deductible Health Plan (HDHP) will continue to be offered. The HDHP has been updated to cover more services once you meet the deductible, which can help reduce costs later in the year. The HDHP's contributions have also been lowered, making it a more budget-friendly option with comparable coverage through Kaiser.



ELIGIBILITY

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

- 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 you must provide proof of eligibility by providing supporting documentation as listed below to the benefits department within 30 days of enrollment:

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**

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.

[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.

ENROLLMENT

Why it is Important to Participate in Open Enrollment

All eligible retirees are requested to actively participate in this open enrollment. This 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 **Madison Alman, malman@fcusd.org, or mailed to ESC, no later than 4:30 pm on Friday, June 5, 2026.**



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
- If retiring at the end of the school and/or contract year, 10-month and 11-month employees will become a retiree effective September 1, 2026
- 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
- If retiring at the end of the school and/or contract year, 10-month and 11-month employees will become a retiree effective September 1, 2026
- 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

We are excited to provide you and your family with a high-quality, affordable alternative healthcare program that significantly reduces 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 and prescription expenses, up to the allowed amount of:

- **Kaiser:** $5,500 for individual plans and $10,000 for Single + One Dependent and family plans. **You are only responsible for your monthly premiums.**
- **Sutter Health:** $6,500 for individual plans and $13,000 for Single + One Dependent and family plans. **You are only responsible for your monthly premiums.**
- **WHA:** $5,500 for individual plans and $11,000 for Single + One Dependent and family plans. **You are only responsible for your monthly premiums.**

With Nonstop 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.

WHAT NONSTOP HEALTH DOES AND DOES NOT 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?

KAISER/SUTTER/WESTERN HEALTH ADV	NONSTOP VISA CARD
	
Your ID card comes from Kaiser/Sutter/Western Health Adv, and includes information relevant to the medical plan. You must present your ID card from Kaiser/Sutter/Western Health Adv during every doctor visit and for prescription purchases. This is important to ensure that Kaiser/Sutter/Western Health Adv 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.

Retiree Rates

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

EARLY RETIREE <65	2026-27 RETIREE ONLY	2026-27 SINGLE + 1 DEP	2026-27 FAMILY
Plans	**Total Rate**	**Total Rate**	**Total Rate**
Kaiser HDHP (w/Nonstop Visa)	$889.83	$1,744.41	$2,502.65
Sutter HDHP (w/Nonstop Visa)	$1,291.62	$2,556.55	$3,644.02
Western Health ADV HDHP (w/Nonstop Visa)	$858.29	$1,667.72	$2,526.20
Plans	**Total Rate**	**Total Rate**	**Total Rate**
Delta Dental PPO	$65.42	$124.29	$189.71
Delta Care DHMO	$20.59	$37.82	$55.95
VSP	$11.51	$23.02	$37.06

When choosing your plan, consider your budget, your preferences, your health and your covered dependents' health. The District offers retirees over 65 the following Medicare Supplement/Medicare Advantage plans:

- Kaiser Senior Advantage – High Option
- Kaiser Senior Advantage – Low Option
- The Hartford Medicare Supplement

Please reach out to the Benefits Department for more information on rates and enrollment forms.



Medical & Prescription Drug Benefits



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 at **www.fcusd.org**.

EARLY RETIREES ONLY	KAISER HDHP (W/NONSTOP VISA)		
	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	$10,000	$10,000	$0
Calendar Year Out-of-Pocket Maximum			
	Includes Deductible	Includes Deductible	After Deductible
Individual Coverage	$5,500	$5,500	$0
Individual within a family	$5,500	$5,500	$0
Family Coverage	$10,000	$10,000	$0
Physician Services			
Physician/Specialist Office Visits	No charge after deductible	In-network medical services covered in full up to deductible - $5,500 individual coverage and $10,000 family coverage	No charge deductible waived
Telehealth Visits	No charge after deductible		$0
Preventive Care	No charge deductible waived		$0
Other Services			
Room & Board Hospital Inpatient (semi-private)	No charge deductible waived	In-network medical services covered in full up to deductible - $5,500 individual coverage and $10,000 family coverage	$0
Outpatient Surgery	No charge deductible waived		$0
Basic X-ray and Lab	No charge deductible waived		$0
Emergency Room Services (copay waived if admitted)	No charge deductible waived		$0*
Urgent Care Services	No charge deductible waived		$0
Ambulance Services	No charge deductible waived		$0
Chiropractic Care (20 visits per calendar year)	$15 copay after deductible		$15 copay after deductible
Acupuncture	Not covered		Not covered
Prescription Drugs			
Retail (30-day supply)	No charge deductible waived	In-network prescriptions covered in full up to deductible - $5,500 individual coverage and $10,000 family coverage	No charge deductible waived
Mail Order (100-day supply)	No charge deductible waived		No charge deductible waived
Specialty (30-day supply)	No charge deductible waived		No charge deductible waived

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.

*If you visit the emergency room and you **ARE NOT** admitted to the hospital, you will incur the charges listed above **PLUS** an extra $100 fee which is payable directly to Nonstop. You cannot use the Nonstop Visa card to pay the extra $100 fee.



Find an In-Network Provider

You can only get care from an in-network Doctor. To find a network Doctor, visit **www.kp.org**, select **Find doctors and locations** and choose your region. Any care received out-of-network will not be covered by Kaiser HDHP Nonstop plan.

Medical & Prescription Drug Benefits (continued)

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 at **www.fcusd.org**.

EARLY RETIREES ONLY	SUTTER HDHP (W/NONSTOP VISA)		
	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 deductible waived		$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 (ded. waived) X-Ray: $50 copay (ded. waived) Preventive: No charge (ded. waived)		$0
Emergency Room Services (copay waived if admitted)	$150 copay after deductible		See Note Below*
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.

*If you visit the emergency room and you **ARE NOT** admitted to the hospital, you will be charged a $100 fee which is payable directly to Nonstop. You cannot use the Nonstop Visa card to pay this fee.

Find an In-Network Provider

You can only get care from an in-network Doctor. Any care received out-of-network will not be covered by Nonstop. To find a network Doctor, visit **www.sutterhealthplan.org**, select **Find a Provider**.

Medical & Prescription Drug Benefits (continued)

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 at **www.fcusd.org**.

EARLY RETIREES ONLY	WESTERN HEALTH ADV HDHP (W/NONSTOP VISA)		
	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	No charge after deductible		See Note Below*
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.

*If you visit the emergency room and you **ARE NOT** admitted to the hospital, you will be charged a $100 fee which is payable directly to Nonstop. You cannot use the Nonstop Visa card to pay this fee.

Find an In-Network Provider

You can only get care from an in-network Doctor. Any care received out-of-network will not be covered by Nonstop. To find a network Doctor, visit **www.westernhealth.com**, select **Search Doctors**, then **Find a Doctor** under **Tools**.

RETIREES OVER 65

When choosing your plan, consider your budget, your preferences, your health and your covered dependents' health. The District offers retirees over 65 the following Medicare Supplement/Medicare Advantage plans:

- Kaiser Senior Advantage – High Option
- Kaiser Senior Advantage – Low Option
- The Hartford Medicare Supplement

For More Information

Benefit summaries for these plans are available under **Benefits/Medicare** on the District's benefits website at **www.fcusd.org**.

Plan Costs

The total monthly costs for these plans can be found on the **Retiree Rates Page 10**.

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 **www.fcusd.org**.

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



Dental Benefits

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 **www.fcusd.org**.

Key Features	DELTACARE[1]	DELTA DENTAL PPO	
		PPO Network	Premier Network & Out-of-Network
Calendar Year Maximum *Per Person*	None	$2,500	$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.

Find an In-Network Dentist

You can get care from any dentist on the PPO plan, but can access discounted pricing for staying in-network. With the DeltaCare plan you must see an in-network dentist. To find a network dentist, visit **www.deltadentalins.com**, select **Find a Dentist** and choose the network for your plan.

ENROLLED RETIREES ONLY

Coverage is through VSP. 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
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

Find an In-Network Provider

You can seek care through any vision provider; however, you receive discounts for seeking care through a contracted VSP provider. To find an in-network provider, visit **www.vsp.com**, select **FIND A DOCTOR** and choose the **Advantage Network**.

Vision Benefits (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**.

Key Contacts

Contact	Phone Number	Website/Email	Plan/Group ID
Kaiser – Medical	**(800) 464-4000**	**www.kp.org**	32170-0009
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**	71691-0048
Delta Dental – Dental	**(800) 422-4234**	**www.deltadentalins.com**	Retiree: 7006-0109
VSP – Vision	**(800) 877-7195**	**www.vsp.com**	30091469
HealthEquity/Wageworks Retiree Billing	**(877) 864-9546**	**mybenefits.wageworks.com**	N/A
Benefits Office Madison Alman (Retirees)	**(916) 294-9000 x104384**	**malman@fcusd.org**	N/A
EPIC Retiree Help Desk	**(877) 374-2151**	**csr@epicbrokers.com**	N/A
Benefits Portal	**N/A**	**www.fcusd.org** Staff/Benefits	N/A
TruHu Benefits Portal	**N/A**		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.

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, 2026
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 x104383

Jenyn Warren
(916) 294-9000 x104382

Madison Alman (Retirees)
(916) 294-9000 x104384

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____.

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.

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 Folsom Cordova Unified School District		4. Employer Identification Number (EIN) 94-6002505
5. Employer address 1965 Birkmont Drive		6. Employer phone number 916-294-9000
7. City Rancho Cordova	8. State CA	9. ZIP code 95742
10. Who can we contact about employee health coverage at this job? Annie DeLand, Liz Ely, Jenyn Warren or Madison Alman		
11. Phone number (if different from above) Annie x104381, Liz x104383, Jenyn x104382, Madison x104384	12. Email address Annie adeland@fcusd.org, Liz lely@fcusd.org , Jenyn jwarren@fcusd.org, Madison malman@fcusd.org	

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:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  ☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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 employees 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. To request special enrollment or obtain more information, contact your health plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

Annual Notices (continued)

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, 2026. Contact your state for more information on eligibility –

To see if any other states have added a premium assistance program since January 31, 2026, 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 7/31/2026)

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:
https://health.alaska.gov/dpa/Pages/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 | Fax: 1-916-440-5676
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
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
Health Insurance Premium Payment Program
All other Medicaid
https://www.in.gov/medicaid | http://www.in.gov/fssa/dfr
Family and Social Services Administration
1-800-403-0864
Member Services: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/medicaid
1-800-338-8366
Hawki: https://hhs.iowa.gov/medicaid/plans-programs/hawki
1-800-257-8563
HIPP: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program | 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://kynect.ky.gov | 1-877-524-4718
Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
https://www.ldh.la.gov/healthy-louisiana
Customer Service: 1-888-342-6207 | **Medicaid:** healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP):
https://www.ldh.la.gov/lahipp | **LaHIPP:** 1-877-697-6703
La.HIPP@la.gov | **Fax:** 1-888-716-9787
100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

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

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

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

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
DHHS.ThirdPartyLiabi@dhhs.nh.gov | 1-603-271-5218
HIPP program toll free: 1-800-852-3345, ext 15218

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid | 1-800-356-1561
CHIP: 1-609-631-2392 | http://www.njfamilycare.org/index.html
1-800-701-0710 (TTY: 711)

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 and CHIP
http://healthcare.oregon.gov/Pages/index.aspx | 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
1-800-692-7462
CHIP: https://www.pa.gov/agencies/dhs/resources/chip
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
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
1-800-440-0493

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

VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program
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/CHIP: 1-800-432-5924

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

WEST VIRGINIA – Medicaid and CHIP
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 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 Nonstop

3. ARBITRATION

Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

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.

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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

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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://apps.truhu.com/pg.aspx?g=f076d783214f40beae1bcaa8c8a1e892

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

Notes





FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT