Elk Grove Benefits Employee Retirement Trust
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COMPLIANCE WITH EGBERT MEDICARE REQUIREMENT – NEW RETIREE

Congratulations on your retirement! Our records indicate that you and/or a covered dependent will be Medicare eligible upon your retirement from EGUSD. In accordance with the EGBERT Summary Plan Description and Retiree Agreement, retirees/dependents shall at age 65, or upon other eligibility enroll in Medicare Parts A & B.

So, what do you need to do?

1. You will receive a completed form from the district titled **"REQUEST FOR EMPLOYMENT INFORMATION"**. To avoid late enrollment penalties, you need to submit this form to Social Security at the same time you enroll in Medicare Parts A & B.
2. Provide EGBERT with evidence that you and/or your dependent are eligible and enrolled in Medicare. A copy of the Medicare Card showing effective dates for both Parts A & B is sufficient. If there is a delay receiving the card, a letter from Social Security with effective dates for Parts A & B and a Medicare number can be substituted.
3. Return completed enrollment form(s) for your chosen EGBERT Medicare coordinated plan.

Enclosed with this packet you will find an enrollment form for the Medicare Advantage plan which corresponds with the health plan you are currently enrolled in. If you wish to switch plans, waive your EGBERT medical benefits, or participate in Private Pay Reimbursement, please notify our office so we may provide you with the proper form(s).

**** <u>All</u> EGBERT forms, your enrollment form(s), and a copy of your Medicare Card should be turned into the EGBERT office no later than <u>15 days prior</u> to your EGBERT effective date. ****

<u>To enroll in Medicare Parts A & B</u>:

- You can call 1-800-772-1213 to schedule an appointment.
- Go online at www.socialsecurity.gov .
- Visit your local Social Security Office. This is typically the best option for those who do not have 40 quarters but may qualify through a current/former spouse or may need to pay a premium for Part A.
- Those eligible for Railroad Retirement Board (RRB) benefits should contact the RRB @ 1-877-772-5772.

<u>Please do not</u> enroll in an INDIVIDUAL Part D Drug Prescription Plan. Medicare Part D is included with your enrollment on our Medicare Advantage Plans. Individual enrollment outside of your EGBERT group insurance will jeopardize your Group Plan Insurance.

SAMPLE

2027 EGBERT Medicare Plan Options* and Monthly Costs

* Retirees and dependents must be in related plans. If you wish to switch plans, your dependent must follow suit. *

Plan	Retiree Only	Retiree +1 – Both Medicare	Retiree +1 – Medicare/Non-Medicare
Kaiser Sr. Advantage	$0.00	$0.00	$683.13
Kaiser Sr. Advantage - Low	$0.00	$0.00	$586.51
Kaiser-NW Sr. Advantage (Parts of OR/WA)	$61.98	$123.96	$443.01
Anthem Medicare Advantage PPO	$45.86	$91.72	-----
Anthem Medicare Advantage PPO & Sutter Health Plan	-----	-----	$862.55
Anthem Medicare Advantage PPO & WHA	-----	-----	$202.90

SAMPLE

Amounts due to EGBERT and premiums due to Medicare are separate bills. Premiums due to Medicare are to be paid for by the retiree, dependent, and/or spouse directly to Social Security.

If you do not enroll in Medicare Parts A & B when first eligible or do not pay your Medicare bill timely:

- **Permanent late penalties incurred from Medicare.**
- **Delay in enrollment, termination, or a lapse in coverage of your chosen insurance plan.**
- **Additional charges by your chosen insurance plan resulting in a significant increase to your monthly EGBERT bill.**
- **Termination of your EGBERT benefits.**

When you receive your Medicare card, please forward a copy along with your completed enrollment form(s) to the EGBERT Office at: **9297 OFFICE PARK CIRCLE, SUITE 110, ELK GROVE, CA 95758**.

Please note if you have additional medical coverage: *The federal agency Centers for Medicare & Medicaid Services (CMS) will not allow you to be enrolled in more than one Medicare plan at a time. If you have additional coverage,* ***please contact the EGBERT Office to discuss your options****.*

Office Hours: Tuesday, Wednesday, Thursday – 9am to 3pm

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name

2. Date ☐☐ / ☐☐ / ☐☐☐☐

3. Employer's Address

City

State ☐☐

Zip Code ☐☐☐☐☐

4. Applicant's Name

5. Applicant's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

6. Employee's Name

7. Employee's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☐ Yes ☐ No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
☐☐ / ☐☐☐☐

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, give the date the coverage ended. (mm/yyyy)
☐☐ / ☐☐☐☐

5. When did the employee work for your company?

From: (mm/yyyy) ☐☐ / ☐☐☐☐

To: (mm/yyyy) ☐☐ / ☐☐☐☐

Still Employed: (mm/yyyy) ☐☐ / ☐☐☐☐

6. If you're a large group health plan and the applicant is entitled, please list the timeframe (all months) that your group health plan was primary payer.

From: (mm/yyyy) ☐☐ / ☐☐☐☐

To: (mm/yyyy) ☐☐ / ☐☐☐☐

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ No

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

3. Date reserve hours ended or will be used? (mm/yyyy)
☐☐ / ☐☐☐☐

All Employers:

Signature of Company Official

Date Signed ☐☐ / ☐☐ / ☐☐☐☐

Title of Company Official

Phone Number (☐☐☐) ☐☐☐ – ☐☐☐☐

SAMPLE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

Form Approved
OMB No. 0938-1230
Expires: 01/25

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number
   ☐☐☐☐ – ☐☐☐ – ☐☐☐☐

2. Your Name (Last Name, First Name, Middle Name)

3. Mailing Address (Number and Street, PO Box, or Route)

4. City | State ☐☐ | Zip Code ☐☐☐☐☐

5. Phone Number (Including Area Code) (☐☐☐) ☐☐☐ – ☐☐☐☐

6. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☐ YES

7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) ☐ YES ☐ NO

7b. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (If yes, complete 7c.) ☐ YES ☐ NO

7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/YYYY)

Dates you (or your spouse) worked for employer that provided health coverage:	Dates of health coverage from employer (or non-profit organization)	Dates you worked as a volunteer outside the U.S.:
Start Date: ☐☐/☐☐☐☐	Start Date: ☐☐/☐☐☐☐	Start Date: ☐☐/☐☐☐☐
Ending Date: ☐☐/☐☐☐☐	Ending Date: ☐☐/☐☐☐☐	Ending Date: ☐☐/☐☐☐☐
Not ended ☐	Not ended ☐	Not ended ☐

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) ☐ YES ☐ NO

9. Remarks:

SAMPLE

10. Written Signature (DO NOT PRINT) **SIGN HERE**	11. Date Signed ☐☐ / ☐☐ / ☐☐☐☐

IF THIS APPLICATION HAS BEEN SIGNED WITH A MARK OR AN (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

12. Signature of Witness	13. Date Signed ☐☐ / ☐☐ / ☐☐☐☐

14. Address of Witness (Street Number and Name, City, State, Zip)

Fact sheet

2026 Medicare costs

Medicare Part A (Hospital Insurance) costs

Part A monthly premium

Most people don't pay a Part A premium because they paid Medicare taxes while working. If you don't get premium-free Part A, you pay up to $565 each month. If you don't buy Part A when you're first eligible for Medicare (usually when you turn 65), you might pay a penalty.

Hospital inpatient stay

In 2026, you pay:

- $1,736 deductible per benefit period
- $0 for the first 60 days of each benefit period (after you pay the deductible)
- $434 per day for days 61–90 of each benefit period
- $868 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)
- All costs for each day after day 150 of the benefit period

Skilled Nursing Facility stay

In 2026, you pay:

- $0 for the first 20 days of each benefit period
- $217 per day for days 21–100 of each benefit period
- All costs for each day after day 100 of the benefit period

Medicare Part B (Medical Insurance) costs

Part B monthly premium

Most people pay the standard Part B monthly premium amount ($202.90 in 2026). Social Security will tell you the exact amount you'll pay for Part B in 2026.

You pay the standard premium amount if you:

- Sign up for Part B for the first time in 2026.
- Don't get Social Security benefits.
- Are directly billed for your Part B premiums.
- Have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $202.90 in 2026.)

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard Part B premium and an income-related monthly adjustment amount.

If your yearly income in 2024 was:			
File individual tax return	**File joint tax return**	**File married & separate tax return**	**You pay each month (in 2026):**
$109,000 or less	$218,000 or less	$109,000 or less	$202.90
above $109,000 up to $137,000	above $218,000 up to $274,000	not applicable	$284.10
above $137,000 up to $171,000	above $274,000 up to $342,000	not applicable	$405.80
above $171,000 up to $205,000	above $342,000 up to $410,000	not applicable	$527.50
above $205,000 and less than $500,000	above $410,000 and less than $750,000	above $109,000 and less than $391,000	$649.20
$500,000 or above	$750,000 or above	$391,000 or above	$689.90

If you have questions about your Part B premium, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you pay a late enrollment penalty, these amounts may be higher.

2026 Part B deductible—$283 before Original Medicare starts to pay

You pay this deductible once each year.

Medicare Advantage Plans (Part C) Premiums

Visit Medicare.gov/plan-compare to find and compare plan premiums. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Medicare Drug Coverage (Part D) Premiums

The chart below shows your estimated drug plan monthly premium based on your income. If your income is above a certain limit, you'll pay an income-related monthly adjustment amount in addition to your plan premium.

If your yearly income in 2024 was:			
File individual tax return	**File joint tax return**	**File married & separate tax return**	**You pay each month (in 2026):**
$109,000	$218,000 or less	$109,000 or less	Your plan premium
above $109,000 up to $137,000	above $218,000 up to $274,000	not applicable	$14.50 + your plan premium
above $137,000 up to $171,000	above $274,000 up to $342,000	not applicable	$37.50 + your plan premium
above $171,000 up to $205,000	above $342,000 up to $410,000	not applicable	$60.40 + your plan premium
above $205,000 and less than $500,000	above $410,000 and less than $750,000	above $109,000 and less than $391,000	$83.30 + your plan premium
$500,000 or above	$750,000 or above	$391,000 or above	$91.00 + your plan premium

2026 Part D national base premium—$38.99

Medicare uses the national base premium to estimate the Part D late enrollment penalty and the income-related monthly adjustment amounts listed in the table above. The national base amount can change each year. If you pay a late enrollment penalty, your total premium amount may be higher.

For detailed information

- Visit **Medicare.gov/basics/costs/medicare-costs** to get more detailed Medicare cost information by service.
- Visit **Medicare.gov/basics/costs/medicare-costs/avoid-penalties** to learn how to avoid late enrollment penalties.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Medicare

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

This product was produced at U.S. taxpayer expense.

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Keenan

Elk Grove Benefits Employee Retirement Trust (EGBERT)

Medicare Plan Benefit Comparison

	Current	Current	Current	
Effective Date	1/1/2027	1/1/2027	1/1/2027	
Carrier Name	**Kaiser Permanente**	**Kaiser Permanente**	**Anthem - $20 MAPD PPO**	
Plan Name	Senior Advantage $20 - High	Senior Advantage $25 - Low	Medicare Advantage PPO	
Eligible Class	Medicare Eligible Retiree	Medicare Eligible Retiree	Medicare Eligible Retiree	
General Plan Information			In-Network	Out-of-Network
Annual Deductible/Individual	$0	$0	$0	$0
Coinsurance	100%	100%	100%	100%
Office Visit/Exam	$20 copay	$25 copay	$20 copay	$20 copay
Outpatient Specialist Visit	$20 copay	$25 copay	$20 copay	$20 copay
Annual Out-of-Pocket Limit/Individual	$1,000	$1,000	$1,500	$1,500
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	No	No
Outpatient Services				
Preventive Services				
Immunizations	100%	100%	100%	100%
Well Woman Exams	100%	100%	100%	100%
Mammograms	100%	100%	100%	100%
Adult Periodic Exams with Preventive Tests	100%	100%	100%	100%
Lab Services	100%	100%	100%	100%
X-ray and/or Simple Diagnostic Test	100%	100%	100%	100%
Complex Radiological Services	100%	100%	100%	100%
Inpatient Hospital Services				
Inpatient Hospitalization	100%	$250 copay per admit	100%	100%
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	$250 copay per admit	100%	100%
Surgical Services				
Outpatient Facility Charge	$20 copay per procedure	$100 copay per procedure	100%	100%
Emergency Services				
Emergency Room	$50 copay (waived if admitted)	$65 copay (waived if admitted)	$50 copay (waived if admitted within 72 hours)	$50 copay (waived if admitted within 72 hours)
Ambulance (Air & Ground)	100%	$75 copay per trip	100%	100%
Urgent Care				
Urgent Care Facility	$20 copay	$25 copay	$20 copay (waived if admitted within 72 hours)	$20 copay (waived if admitted within 72 hours)
Mental Health Benefits				
Inpatient Care	100%	$250 copay per admit	100% - Unlimited days	100% - Unlimited days
Outpatient Care	$20 copay individual therapy; $10 copay group therapy	$25 copay individual therapy; $12 copay group therapy	$20 copay	$20 copay
Substance Abuse				
Inpatient Care				
Inpatient Hospitalization	100%	$250 copay per admit	100%	100%
Inpatient Detoxification Services	100%	$250 copay per admit	100%	100%
Outpatient Care				
Outpatient Services	$20 copay individual therapy; $5 copay group therapy	$25 copay individual therapy; $5 copay group therapy	$20 copay	$20 copay
Prescription Drug Benefits				
Prescription Drug Annual Out-of-Pocket Limit/Individual	$2,400 CMS Requirement	$2,400 CMS Requirement	$2,400 CMS Requirement	
Generic	$10 copay	$10 copay	$0 copay Select/$10 copay	Not covered
Brand (Formulary/Preferred)	$20 copay	$25 copay	$20 copay	Not covered
Brand (Non-Formulary/Non-preferred)	--	--	$35 copay	Not covered
Specialty	$20 copay	$25 copay	$35 copay	Not covered
Medicare Part B Drugs	Generic: $10 copay; Brand: $20 copay	Generic: $10 copay; Brand: $25 copay	20% coinsurance	20% coinsurance
Number of Days Supply	30 days	30 days	30 days	Not covered
Mail Order				
Generic	$20 copay	$20 copay	$0 copay Select/$20 copay	Not covered
Brand (Formulary/Preferred)	$40 copay	$50 copay	$40 copay	Not covered
Brand (Non-Formulary/Non-preferred)	--	--	$70 copay	Not covered
Number of Days Supply for Mail Order	100 days	100 days	90 days	Not covered

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.

Keenan

Elk Grove Benefits Employee Retirement Trust (EGBERT)

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Plan Name	Senior Advantage $20 · High	Senior Advantage $25 · Low	Medicare Advantage PPO	
Eligible Class	Medicare Eligible Retiree	Medicare Eligible Retiree	Medicare Eligible Retiree	
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	100%	100%	100%	100%
Home Health Care	100%	100%	100%	100%
Skilled Nursing or Extended Care Facility	100% Limited to 100 days per benefit period	100% Limited to 100 days per benefit period	100% for days 1-100; 100 day limit per benefit period	100% for days 1-100; 100 day limit per benefit period
Hospice Care	100%	100%	$20 copay	$20 copay
Chiropractic Services	$20 copay Limited to Medicare allowed chiro benefit	$20 copay; limited to Medicare allowed chiro benefit	$20 copay Limited to Medicare allowed Chiro benefit	$20 copay Limited to Medicare allowed Chiro benefit
Acupuncture	Not covered	Not covered	$15 copay Limited to Medicare covered services	$15 copay Limited to Medicare covered services
Vision				
Examination	$20 copay	$25 copay	100%, routine vision exam, one per year ($70 OON)	
Materials	$150 eyewear allowance every 24 months	$150 eyewear allowance every 24 months	$100 Allowance every two years $0 Non-elective Contacts Must use Blue View Vision	
Hearing				
Screening	$20 copay	$25 copay	$0 routine hearing exam · 1 per year $70 Max · every year · Hearing exams & Evaluations	
Aid(s)	$1,000 allowance per aid every 36 months	Not covered	$0 fitting & evaluations: 1 per hearing aid $1000 Allowance per ear, $2,000 total every 3 years Must use TruHearing	
Outpatient Rehabilitative Therapy Services				
Physical, Occupational, Speech	$20 copay	$25 copay	$20 copay	$20 copay
Wellness Program				
Wellness Program · Included	One Pass	One Pass	Silver Sneakers	

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