FRESNO UNIFIED SCHOOL DISTRICT

2309 Tulare Street Fresno, CA 93721 (559) 457-3520 Fax No. (559) 457-3760

Open Enrollment Form

EFFECTIVE: JANUARY 1, 2021

COBRA PARTICIPANTS

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID	☐ SINGLE ☐ MARRIED ☐ DIVORCE ☐ WIDOWED ☐ DOMESTIC PARTNERSHIP
MAILING ADDRESS		BIRTHDATE / TELEPHONE NO.	☐ MALE ☐ FEMALE
CITY STATE ZIP CODE		Please check your status with Fresno Unified School District ☐ COBRA ☐ LEAVE	

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE? _____

Are you or any family members covered by another group plan? ☐ NO ☐ YES _____ GROUP NAME

MEDICAL PLAN OPTION A ☐ CHECK BOX IF NO CHANGE IS REQUIRED

	18 Month Coverage	19 – 29 Month Coverage *
One Party	**$ 595.00**	**$ 875.00**
Two Party	**$ 1,189.00**	**$ 1,749.00**
Three Or More	**$ 1,735.00**	**$ 2,552.00**

***19 – 29 Month Coverage (extended coverage due to disability)**

Office Visit Co-Pay $15.00

***Usual, Customary and Reasonable**

	PPO Providers	Non PPO
Covered Services	90% of Blue Cross Rate	60% of UCR*
Calendar Year Deductible	$250 Individual $500 Family	$750 Individual $1,500 Family
Annual Out-Of-Pocket Maximum	$2,100 Individual $4,200 Family	$10,000 Individual $20,000 Family

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

MEDICAL PLAN OPTION B ☐ CHECK BOX IF NO CHANGE IS REQUIRED

	18 Month Coverage	19 – 29 Month Coverage*
One Party	**$ 531.00**	**$ 781.00**
Two Party	**$ 1,063.00**	**$ 1,564.00**
Three or more	**$ 1,551.00**	**$ 2,281.00**

***19 – 29 Month Coverage (extended coverage due to disability)**

Office Visit Co-Pay $25.00

***Usual, Customary and Reasonable**

	PPO Providers	Non PPO
Covered Services	70% of Blue Cross Rate	50% of UCR*
Calendar Year Deductible	$1,000 Individual $2,000 Family	$3,000 Individual $6,000 Family
Annual Out-Of-Pocket Maximum	$5,700 Individual $11,400 Family	$12,000 Individual $24,000 Family

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

MEDICAL PLAN OPTION C ☐ **CHECK BOX IF NO CHANGE IS REQUIRED**

KAISER PERMANENTE HEALTH PLAN

	18 Month Coverage	19 – 29 Month Coverage*
One Party	**$ 1,181.00**	**$ 1,771.00**
Two Party	**$ 1,181.00**	**$ 1,771.00**
Three or more	**$ 1,181.00**	**$ 1,771.00**

***19 – 29 Month Coverage (extended coverage due to disability)**

Office Visit Co-Pay $15.00

If you are choosing Kaiser Permanente Health Plan for your coverage, you must also complete the KAISER ENROLLMENT FORM (California Region Group Enrollment/Change Form).

Covered services for care must be obtained at a Kaiser facility (Except in emergencies)

Covered Services	90% after Deductible	
Calendar Year Deductible	$250 Individual	$500 Family
Annual Out-Of-Pocket Maximum	$2,500 Individual	$5,000 Family

Kaiser Permanente enrolled participants will continue to use the Plan's Chiropractic benefits provided through PhysMetrics and the Plan's Employee Assistance Program (EAP) benefits through Claremont EAP. The Kaiser Permanente Health Plan will include Mental Health service benefits as well as Acupuncture benefits.

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

DENTAL PLANS ☐ **CHECK BOX IF NO CHANGE IS REQUIRED**

DELTA DENTAL PPO

		PPO	NON-PPO
Maximums	Per patient per calendar year ……..	$2,000	$1,000
	Dental Accident per calendar year …..	$1,000	$1,000
	Orthodontic lifetime maximum ……..	N/A	N/A

Family coverage is available at the rates listed. **Monthly Cost: 12 Month**

Cross Coverage is not available

One Party	**$ 38.00**
Two Party	**$ 77.00**
Three Party of more	**$115.00**

****MUST USE PPO PROVIDER FOR PPO COVERAGE****

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family
☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

UHC DENTAL DIRECT

Plan coverage includes:
Office Exam, X-Rays and
(2) Cleanings annually

Includes Orthodontic coverage for dependents and adults.
Some procedures may require co-payments.

Employee and Family $ 51.00

****MUST USE UHC DENTAL DIRECT PROVIDERS****

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family
☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

VISION PLAN ☐ **CHECK BOX IF NO CHANGE IS REQUIRED**

MEDICAL EYE SERVICES (MES)

Plan coverage includes: Exam - Once every 12 months ($5 Co-pay)
Lenses - Once every 12 months (If Rx changes)
Frames - Once every 24 months (Frames or Contact Lenses, up to $130)

Employee and Family $ 11.00

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

****If you are enrolled in Medical Plan C (Kaiser Permanente), your vision coverage is offered by Kaiser Permanente.****

FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:
SSN# COPY / BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES
AND if married or in a Domestic Partnership, front page of your most recently filed federal tax return (1040 form)

FIRST NAME	LAST NAME	GENDER	AGE	BIRTHDATE	SOCIAL SECURITY
☐ DOMESTIC PARTNER ☐ SPOUSE		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			

Verified by:	Effective Date:

EMPLOYEE SIGNATURE_____ **Date** _____

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

Company name FRESNO UNIFIED SCHOOL DISTRICT		Hire date (mm/dd/yyyy)
Group number 603815	Enrollment unit **7000**	Effective enrollment/ change date: **01/01/2021**

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance) New group: ☐ Yes ☒ No

☐ New Hire (complete sections A, B, C, D) ☒ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☒ Deductible Plan ☐ Other

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known) | Social Security No.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) Gender ☐ M ☐ F

Home Address | City | State | ZIP

Work Phone | Home Phone | Email

Ethnicity | Preferred Language

C. FAMILY: For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner Gender ☐ M ☐ F Spouse/domestic partner name: Former last name (if any):	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Child Gender ☐ M ☐ F Dependent name: Relationship:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Child Gender ☐ M ☐ F Dependent name: Relationship:	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. 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 all Kaiser Permanente Plans **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.*

KAISER PERMANENTE®