FRESNO UNIFIED SCHOOL DISTRICT

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

Open Enrollment Form
Effective January 1, 2019
Medicare Eligible Retirees

RETIREE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC PARTNERSHIP
MAILING ADDRESS			
CITY STATE ZIP CODE	BIRTHDATE	TELEPHONE NO.	☐ MALE ☐ FEMALE

OTHER HEALTH INSURANCE INFORMATION

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

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

DENTAL PLANS ☐ CHECK BOX IF NO CHANGE IS REQUIRED

DELTA DENTAL PPO (DISTRICT PLAN)

RETIREES AGE 65 AND UP

Monthly Premiums

	COBRA Rate	Ed Code Rate*
Retiree Only	$ 44.00	$ 44.00
Retiree and Spouse	$ 89.00	$ 89.00
Retiree and Family	$132.00	N/A

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

***Dependent child(ren) coverage is no longer provided to retirees on ED Code 7000 effective September 1, 2013.**

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

UHC DENTAL DIRECT

RETIREES AGE 65 AND UP

Monthly Premiums

	COBRA Rate	Ed Code Rate*
Retiree Only	$ 51.00	$ 29.00
Retiree and Spouse	$ 51.00	$ 58.00
Retiree and Family	$ 51.00	N/A

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

***Dependent child(ren) coverage is no longer provided to retirees on ED Code 7000 effective September 1, 2013.**

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

VISION PLAN ☐ CHECK BOX IF NO CHANGE IS REQUIRED

MEDICAL EYE SERVICES (MES)

RETIREES AGE 65 AND UP

Monthly Premiums

	COBRA Rate	Ed Code Rate*
Retiree Only	$ 12.00	$ 7.00
Retiree and Spouse	$ 12.00	$ 11.00
Retiree and Family	$ 12.00	N/A

Plan coverage:
Exam – Once every 12 months …. $5 Co-Pay
Lenses – Once every 12 months …. (If Rx change)
Frames – Once every 24 months …. (Frames or Lenses, up to $130)

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

****If you are enrolled in Medical Plan C (Kaiser Permanente), your vision coverage is offered by Kaiser Permanente.****
***Dependent child(ren) coverage is no longer provided to retirees on ED Code 7000 effective September 1, 2013.**

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

Premiums	65-74	75+
Retiree Only	**$10.00**	**N/A**
Retiree & Child	**$20.00**	**N/A**
Retiree & Spouse /Domestic Partner	**$20.00**	**N/A**
Retiree & Family	**$40.00 Max**	**N/A**

Office Visit Co-Pay $15.00

Note: No cost for Retiree or Spouse when age 75+ is reached.

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

***Usual, Customary and Reasonable**

- ☐ **Retiree Only**
- ☐ **Add Dependent(s)**
- ☐ **Add Family**
- ☐ **Delete Retiree**
- ☐ **Delete Dependent(s)**
- ☐ **Delete Family**

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

Premiums	65-74	75+
Retiree Only	**$10.00**	**N/A**
Retiree & Child	**$20.00**	**N/A**
Retiree & Spouse Domestic Partner	**$20.00**	**N/A**
Retiree & Family	**$40.00 Max**	**N/A**

Office Visit Co-Pay $25.00

Note: No cost for Retiree or Spouse when age 75+ is reached.

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

***Usual, Customary and Reasonable**

- ☐ **Retiree Only**
- ☐ **Add Dependent(s)**
- ☐ **Add Family**
- ☐ **Delete Retiree**
- ☐ **Delete Dependent(s)**
- ☐ **Delete Family**

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

ALTERNATE MEDICAL PLAN

Premiums	65-74	75+
Retiree Only	$10.00	N/A
Retiree & Child	$20.00	N/A
Retiree & Spouse /Domestic Partner	$20.00	N/A
Retiree & Family	$40.00 Max	N/A

KAISER PERMANENTE SENIOR ADVANTAGE

If you are choosing Kaiser Permanente Senior Advantage for your coverage, you must also complete the KAISER ENROLLMENT FORM (California Region Group Enrollment/Change Form) and the KAISER SENIOR ADVANTAGE FORM (Group Election Request Form).

Office Visit Co-Pay $15.00

Note: No cost for Retiree or Spouse when age 75+ is reached.

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

Covered Services	Most 100% after Applicable Co-Pay		
Calendar Year Deductible	None		
Annual Out-Of-Pocket Maximum	$1,500 Individual	$3,000 Family	Max

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.

☐ **Retiree Only** ☐ **Delete Retiree**
☐ **Add Dependent(s)** ☐ **Delete Dependent(s)**
☐ **Add Family** ☐ **Delete Family**

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			
☐ SON ☐ DAUGHTER		F / M			

- **The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.**
- **Please notify the Benefits Office of any change in Health Coverage within 31 days of event.**
- **You are required to notify the District within 60 days following the date on which any dependent no longer meets the eligibility criteria for dependent coverage (including divorce or legal separation; and the termination, dissolution or nullification of Domestic Partnership). Failure to notify the District within the adequate time period may cause you to be responsible for the reimbursement of any claims paid for ineligible dependents.**

Verified by:	Effective Date:

RETIREE 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 0002	Effective enrollment/ Change Date **01/01/2019**

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