

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

Active Employees

EMPLOYEE INFORMATION

LAST NAME		FIRST NAME		EMPLOYEE ID		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DOMESTIC PARTNERSHIP <input type="checkbox"/> EMPLOYEE ON LEAVE	
MAILING ADDRESS				BIRTHDATE	TELEPHONE NO.	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
CITY	STATE	ZIP CODE		DEPT./SITE			
Is your spouse employed? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE _____ Are you or any family members covered by another group plan? <input type="checkbox"/> NO <input type="checkbox"/> YES _____ <div style="text-align: right;">GROUP NAME</div>							

MEDICAL PLAN OPTION A

CHECK BOX IF NO CHANGE IS REQUIRED

DISTRICT MEDICAL PLAN			<p>Health Assessment Premiums – All employees enrolled in the District’s medical plans will pay, through payroll deduction, an additional \$10 or \$12 Health Assessment Fee depending on whether you are paid 10 or 12 monthly payments.</p> <p style="text-align: center;">Office Visit Co Pay \$15.00</p>												
<u>Premiums</u>	12 Month	10 Month													
Employee Only	\$160	\$192													
Employee, Child/Children	\$175	\$210													
Employee & Spouse/Domestic Partner	\$220	\$264													
Employee & Family	\$230	\$276													
Covered Services Calendar Year Deductible Annual Out-Of-Pocket Maximum			<p style="text-align: center;">*Usual, Customary and Reasonable</p> <table border="0"> <tr> <td>PPO Providers</td> <td>Non PPO</td> </tr> <tr> <td>90% of Blue Cross Rate</td> <td>60% of UCR*</td> </tr> <tr> <td>\$250 Individual</td> <td>\$750 Individual</td> </tr> <tr> <td>\$500 Family</td> <td>\$1,500 Family</td> </tr> <tr> <td>\$2,100 Individual</td> <td>\$10,000 Individual</td> </tr> <tr> <td>\$4,200 Family</td> <td>\$20,000 Family</td> </tr> </table>	PPO Providers	Non PPO	90% of Blue Cross Rate	60% of UCR*	\$250 Individual	\$750 Individual	\$500 Family	\$1,500 Family	\$2,100 Individual	\$10,000 Individual	\$4,200 Family	\$20,000 Family
PPO Providers	Non PPO														
90% of Blue Cross Rate	60% of UCR*														
\$250 Individual	\$750 Individual														
\$500 Family	\$1,500 Family														
\$2,100 Individual	\$10,000 Individual														
\$4,200 Family	\$20,000 Family														
<input type="checkbox"/> Employee Only <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Add Family <input type="checkbox"/> Delete Employee <input type="checkbox"/> Delete Dependent(s) <input type="checkbox"/> Delete Family															

MEDICAL PLAN OPTION B

CHECK BOX IF NO CHANGE IS REQUIRED

ALTERNATE MEDICAL PLAN			<p>Health Assessment Premiums – All employees enrolled in the District’s medical plans will pay, through payroll deduction, an additional \$10 or \$12 Health Assessment Fee depending on whether you are paid 10 or 12 monthly payments.</p> <p style="text-align: center;">Office Visit Co Pay \$25.00</p>												
<u>Premiums</u>	12 Month	10 Month													
Employee Only	\$60	\$72													
Employee, Child/Children	\$70	\$84													
Employee & Spouse/Domestic Partner	\$90	\$108													
Employee & Family	\$100	\$120													
Covered Services Calendar Year Deductible Annual Out-Of-Pocket Maximum			<p style="text-align: center;">*Usual, Customary and Reasonable</p> <table border="0"> <tr> <td>PPO Providers</td> <td>Non PPO</td> </tr> <tr> <td>70% of Blue Cross Rate</td> <td>50% of UCR*</td> </tr> <tr> <td>\$1,000 Individual</td> <td>\$3,000 Individual</td> </tr> <tr> <td>\$2,000 Family</td> <td>\$6,000 Family</td> </tr> <tr> <td>\$5,700 Individual</td> <td>\$12,000 Individual</td> </tr> <tr> <td>\$11,400 Family</td> <td>\$24,000 Family</td> </tr> </table>	PPO Providers	Non PPO	70% of Blue Cross Rate	50% of UCR*	\$1,000 Individual	\$3,000 Individual	\$2,000 Family	\$6,000 Family	\$5,700 Individual	\$12,000 Individual	\$11,400 Family	\$24,000 Family
PPO Providers	Non PPO														
70% of Blue Cross Rate	50% of UCR*														
\$1,000 Individual	\$3,000 Individual														
\$2,000 Family	\$6,000 Family														
\$5,700 Individual	\$12,000 Individual														
\$11,400 Family	\$24,000 Family														
<input type="checkbox"/> Employee Only <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Add Family <input type="checkbox"/> Delete Employee <input type="checkbox"/> Delete Dependent(s) <input type="checkbox"/> Delete Family															

MEDICAL PLAN OPTION C

CHECK BOX IF NO CHANGE IS REQUIRED

ALTERNATE MEDICAL PLAN

KAISER PERMANENTE HEALTH PLAN

<u>Premiums</u>	12 Month	10 Month
Employee Only	\$160	\$192
Employee, Child/Children	\$175	\$210
Employee & Spouse/Domestic Partner	\$220	\$264
Employee & Family	\$230	\$276

Health Assessment Premiums – All employees enrolled in the District’s medical plans will pay, through payroll deduction, an additional \$10 or \$12 Health Assessment Fee depending on whether you are paid 10 or 12 monthly payments.

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 (DISTRICT PLAN)

Family coverage is available at the rates listed.

		Monthly Cost:	
		12 Month	10 Month
Cross Coverage is not available	Employee	No Cost	
	One Dependent	\$33.05	\$39.66
	Two or more	\$51.57	\$61.88
Maximums		PPO	NON-PPO
	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

Employee and Family

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

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

UHC DENTAL DIRECT

Employee and Family No Cost

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

Plan coverage includes:

Office Exam, X-Rays, and
(2) Cleanings Annually

Employee and Family

****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)

Employee and/or Family..... No Cost

Plan coverage:

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 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
<input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> SPOUSE		F / M			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		F / M			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		F / M			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		F / M			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		F / M			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		F / M			
<input type="checkbox"/> SON <input type="checkbox"/> 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:

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 0000 Actives	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 <input type="checkbox"/> M <input type="checkbox"/> 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)

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

