FRESNO UNIFIED SCHOOL DISTRICT

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

Open Enrollment Form

EFFECTIVE: JANUARY 1, 2020

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 PLAN NAME

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

	18 Month Coverage	19 – 29 Month Coverage *
One Party	**$ 520.00**	**$ 764.00**
Two Party	**$ 1,039.00**	**$ 1,528.00**
Three Or More	**$ 1,516.00**	**$ 2,230.00**

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

Office Visit Co-Pay $15.00

***Usual, Customary and Reasonable**

	PPO Providers	Non PPO Providers
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	**$ 464.00**	**$ 682.00**
Two Party	**$ 929.00**	**$ 1,366.00**
Three or more	**$ 1,355.00**	**$ 1,993.00**

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

Office Visit Co-Pay $25.00

***Usual, Customary and Reasonable**

	PPO Providers	Non PPO Providers
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	$ 1,131.00	$ 1,696.00
Two Party	$ 1,131.00	$ 1,696.00
Three or more	$ 1,131.00	$ 1,696.00

***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 includes Mental Health and Substance Abuse 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

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

Family coverage is available at the rates listed.

Monthly Cost: 12 Month

Cross Coverage is not available

One Party	**$ 44.00**
Two Party	**$ 89.00**
Three Party of more	**$132.00**

****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 Two (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 $ 12.00

☐ 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** _____