# 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

**ED CODE 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 ☐ ED CODE | |

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

### ED CODE PREMIUMS

| | MEDICARE | NON-MEDICARE |
|---|---|---|
| **One Party** | **$ 492.00** | **$ 1,189.00** |
| **Two Party** | **$ 984.00** | **$ 2,378.00** |

**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<br>$500 Family | $750 Individual<br>$1,500 Family |
| Annual Out-Of-Pocket Maximum | $2,100 Individual<br>$4,200 Family | $10,000 Individual<br>$20,000 Family |

☐ **Retiree Only** ☐ **Add Spouse** ☐ **Delete Retiree** ☐ **Delete Spouse**

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

### ED CODE PREMIUMS

| | MEDICARE | NON-MEDICARE |
|---|---|---|
| **One Party** | **$ 442.00** | **$ 1,057.00** |
| **Two Party** | **$ 883.00** | **$ 2,119.00** |

**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<br>$2,000 Family | $3,000 Individual<br>$6,000 Family |
| Annual Out-Of-Pocket Maximum | $5,700 Individual<br>$11,400 Family | $12,000 Individual<br>$24,000 Family |

☐ **Retiree Only** ☐ **Add Spouse** ☐ **Delete Retiree** ☐ **Delete Spouse**

| Verified by: | Effective Date: |
|---|---|
| | |

**EMPLOYEE SIGNATURE**_____ **Date** _____

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

### KAISER PERMANENTE HEALTH PLAN and SENIOR ADVANTAGE

| | MEDICARE (Senior Advantage) | NON-MEDICARE |
|---|---|---|
| **One Party** | **$ 298.55** | **$ 797.53** |
| **Two Party** | **$ 597.10** | **$ 1,595.06** |
| **Two Party** (One Spouse is Medicare age) | **$ 1,096.08** | |

**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.

☐ **Retiree Only** ☐ **Add Spouse** ☐ **Delete Retiree** ☐ **Delete Spouse**

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

### DELTA DENTAL PPO

***Cross Coverage is not available.***

| | | 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 |

### ED CODE PREMIUMS

| | |
|---|---|
| **One Party** | **$ 44.00** |
| **Two Party** | **$ 89.00** |

****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** ☐ **Add Spouse** ☐ **Delete Retiree** ☐ **Delete Spouse**

### 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.**

### ED CODE PREMIUMS

| | |
|---|---|
| **One Party** | **$29.00** |
| **Two Party** | **$58.00** |

****MUST USE UHC Dental Direct Provider****

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

☐ **Retiree Only** ☐ **Add Spouse** ☐ **Delete Retiree** ☐ **Delete Spouse**

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

**MEDICAL EYE SERVICES (MES)**

Plan coverage includes: Exam - Once every 12 months ($5 Copay)
Lenses - Once every 12 months (If prescription changes)
Frames - Once every 24 months (Frames and Contact Lenses, up to $130)

**ED CODE PREMIUMS**

| | |
|---|---|
| **One Party** | **$7.00** |
| **Two Party** | **$11.00** |

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

☐ **Retiree Only** ☐ **Add Spouse** ☐ **Delete Retiree** ☐ **Delete Spouse**

****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<br>☐ SPOUSE | | 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 required time period may cause you to be responsible for the reimbursement of any claims paid for ineligible dependents.**

**EMPLOYEE SIGNATURE**_____ **Date** _____

| Verified by: | Effective Date: |
|---|---|
| | |