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
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

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

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 prescription changes)
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.**

Verified by:	Effective Date:

RETIREE SIGNATURE_____ **Date** _____

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 premium cost for Retiree or Spouse when age 75+ is reached.

	PPO Providers	Non PPO Providers
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** ☐ **Delete Retiree**
☐ **Add Dependent(s)** ☐ **Delete Dependent(s)**
☐ **Add Family** ☐ **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 premium cost for Retiree or Spouse when age 75+ is reached.

	PPO Providers	Non PPO Providers
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** ☐ **Delete Retiree**
☐ **Add Dependent(s)** ☐ **Delete Dependent(s)**
☐ **Add Family** ☐ **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 premium 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	100% after Applicable Co-Pay	
Calendar Year Deductible	None	
Annual Out-Of-Pocket Maximum	$1,500 Individual	$3,000 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**	☐ **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 required 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** _____