FRESNO UNIFIED SCHOOL DISTRICT

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

Open Enrollment Form

EFFECTIVE: JANUARY 1, 2021

Active Employees

EMPLOYEE INFORMATION

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

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

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

Are you the parent/guardian of an FUSD employee that is under the age of 26? ☐ YES ☐ NO If yes, what is your dependent child's name and employee ID#? _____

Are you the dependent child of a FUSD employee? ☐ YES ☐ NO If yes, are you covered under that employee's health plan? ☐ YES ☐ NO

Please provide the name and employee ID # of the person whom you have FUSD coverage through: _____

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

DISTRICT MEDICAL PLAN

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.

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

Office Visit Co Pay $15.00

***Usual, Customary and Reasonable**

	PPO Providers	**Non PPO**
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

ALTERNATE MEDICAL PLAN

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.

Premiums	**12 Month**	**10 Month**
Employee Only	**$60**	**$72**
Employee, Child/Children	**$70**	**$84**
Employee & Spouse/Domestic Partner	**$90**	**$108**
Employee & Family	**$100**	**$120**

Office Visit Co Pay $25.00

***Usual, Customary and Reasonable**

	PPO Providers	**Non PPO**
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

ALTERNATE MEDICAL PLAN — KAISER PERMANENTE HEALTH PLAN

Premiums	**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.

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)

Office Visit Co-Pay $15.00

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.

Cross Coverage is not available

	Monthly Cost: 12 Month	**10 Month**
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

Plan coverage includes:
Office Exam, X-Rays and
(2) Cleanings Annually

PLEASE NOTE: If both you and your Spouse/DP works for FUSD and are covered under Delta Dental, you cannot enroll each other nor the same dependent children under Delta Dental. There is no Coordination of Benefits under Delta Dental through FUSD.

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
☐ DOMESTIC PARTNER ☐ SPOUSE		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		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:

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 **01/01/2021**

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®