FRESNO UNIFIED SCHOOL DISTRICT

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

Open Enrollment Form

EFFECTIVE: JANUARY 1, 2013

Active and Non-Medicare (under Age 65)
Retired Employees

EMPLOYEE INFORMATION

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

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

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

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

DISTRICT MEDICAL 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.

Office Visit Co Pay $15.00

***Usual, Customary and Reasonable**

	PPO Providers	**Non PPO**
Covered Services	80% of Blue Cross Rate	60% of UCR*
Calendar Year Deductible	$250 Individual	$750 Individual
	$500 Family	$1,500 Family
Annual Out-Of Pocket Maximum	$5,000 Individual	$10,000 Individual
	$10,000 Family	$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

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

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 $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	$3,000 Individual
	$2,000 Family	$6,000 Family
Annual Out-Of Pocket Maximum	$6,000 Individual	$12,000 Individual
	$12,000 Family	$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	80% after Deductible	
Calendar Year Deductible	$250 Individual	$500 Family
Annual Out-Of Pocket Maximum	$5,000 Individual	$10,000 Family

Kaiser Permanente enrolled participants will continue to use the Plan's Chiropractic benefits provided through ChiroMetrics and the Plan's Employee Assistance Program (EAP) benefits through Claremont EAP. The Kaiser Permanente Health Plan will include Mental Health service benefits as noted on the comparison.

☐ 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)

ACTIVES

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

RETIREES UNDER AGE 65

Monthly Premiums

RETIREE	**$ 51.00**
RETIREE/SPOUSE	**$102.00**
RETIREE/FAMILY	**$149.00**

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/PACIFIC UNION

ACTIVES

Employee and Family ……. No Cost

Includes Orthodontic coverage for dependents between ages 10 and 19. Some procedures may require co-payments.

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

RETIREES UNDER AGE 65

Monthly Premiums

RETIREE	**$31.00**
RETIREE/SPOUSE	**$62.00**
RETIREE/FAMILY	**$87.00**

Employee and Family
MUST USE UHC/PACIFIC UNION Provider

☐ 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)

ACTIVES

Employee Only……. No Cost

NO ADDITIONAL COST TO EMPLOYEE FOR FAMILY COVERAGE

Plan coverage:
Exam, Once every 12 months $5. Co-pay - Lenses, Once every 12 months… (If Rx changes) - Frames, Once every 24 months $0 (frames or Lenses)

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

RETIREES UNDER AGE 65

Monthly Premiums

RETIREE	**$ 7.00**
RETIREE/SPOUSE	**$ 11.00**
RETIREE/FAMILY	**$ 17.00**

Plan coverage:
Exam - Once every 12 months …… $5. Co-pay
Lenses - Once every 12 months …… (If Rx changes)
Frames - Once every 24 months …… $0 (frames or Lenses)

☐ **ADD Coverage**

- ☐ Retiree Only
- ☐ Retiree/Spouse Coverage
- ☐ Retiree/Family Coverage
- ☐ Dependent or Spouse

☐ **DROP Coverage**

- ☐ Delete Retiree Coverage
- ☐ Delete Dependent Coverage
- ☐ Delete Family Coverage

FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:
BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES / SS# COPY

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.**

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	Effective enrollment/ change date

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.
☐ 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., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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 and in the Certificate of Insurance.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2) the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.

☒ _____

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) Date

KAISER PERMANENTE®

Note: Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.