

FRESNO UNIFIED SCHOOL DISTRICT

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

Open Enrollment Form

EFFECTIVE: JANUARY 1, 2027

COBRA PARTICIPANTS

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE/COBRA ID	☐ SINGLE ☐ MARRIED ☐ DIVORCE ☐ WIDOWED ☐ DOMESTIC PARTNERSHIP
MAILING ADDRESS		BIRTHDATE	TELEPHONE NO. ☐ MALE ☐ FEMALE ☐ NON-BINARY ☐ DECLINE TO STATE
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 NAME			

MEDICAL PLAN OPTION A

☐ CHECK BOX IF NO CHANGE IS REQUIRED

Monthly Premium		Office Visit Co-Pay \$15.00
	<u>18 Month Coverage</u>	<u>19 – 29 Month Coverage (extended coverage due to disability)</u>
One Party	\$ 966.00	\$ 1,421.00
Two Party	\$ 1,934.00	\$ 2,844.00
Three Or More	\$ 2,821.00	\$ 4,148.00
Covered Services	<u>PPO Providers</u> 100% of Aetna PPO Rate	<u>Non-PPO Providers</u> 60% of UCR*
Calendar Year Deductible	\$250 Individual / \$500 Family	\$750 Individual / \$1,500 Family
Medical Annual Out-Of-Pocket Max	\$2,100 Individual / \$4,200 Family	\$10,000 Individual / \$20,000 Family
*Usual, Customary and Reasonable		
☐ Participant Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Participant ☐ Delete Dependent(s) ☐ Delete Family		

MEDICAL PLAN OPTION B

☐ CHECK BOX IF NO CHANGE IS REQUIRED

Monthly Premium		Office Visit Co-Pay \$25.00
	<u>18 Month Coverage</u>	<u>19 – 29 Month Coverage (extended coverage due to disability)</u>
One Party	\$ 863.00	\$ 1,270.00
Two Party	\$ 1,729.00	\$ 2,543.00
Three Or More	\$ 2,821.00	\$ 3,707.00
Covered Services	<u>PPO Providers</u> 80% of Aetna PPO Rate	<u>Non-PPO Providers</u> 50% of UCR*
Calendar Year Deductible	\$1,000 Individual / \$2,000 Family	\$3,000 Individual / \$6,000 Family
Medical Annual Out-Of-Pocket Max	\$5,700 Individual / \$11,400 Family	\$12,000 Individual / \$24,000 Family
*Usual, Customary and Reasonable		
☐ Participant Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Participant ☐ Delete Dependent(s) ☐ Delete Family		

MEDICAL PLAN OPTION C

☐ CHECK BOX IF NO CHANGE IS REQUIRED

KAISER PERMANENTE HEALTH PLAN

<u>Monthly Premium</u>	<u>18 Month Coverage</u>	<u>19 – 29 Month Coverage (extended coverage due to disability)</u>
One Party	\$ 1,585.00	\$ 2,378.00
Two Party	\$ 1,585.00	\$ 2,378.00
Three Or More	\$ 1,585.00	\$ 2,378.00

Care for covered services must be obtained at a Kaiser facility (except in emergencies)

Covered Services	100% after Deductible
Calendar Year Deductible	\$250 Individual / \$500 Family
Annual Out-Of-Pocket Maximum	\$2,500 Individual / \$5,000 Family

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).

Kaiser Permanente enrolled participants will continue to use the Plan's Chiropractic benefits provided through SimpleTherapy and the Plan's Employee Assistance Program (EAP) benefits through Claremont EAP. The Kaiser Permanente Health Plan includes Mental Health and Substance Abuse services benefits, as well as Acupuncture benefits.

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

DENTAL PLANS

☐ CHECK BOX IF NO CHANGE IS REQUIRED

DELTA DENTAL PPO

		PPO	Non-PPO
Maximums	Per patient per calendar year	\$2,500	\$1,500
	Dental Accident per calendar year	\$1,000	\$1,000
	Orthodontic lifetime maximum	50% up to \$2000	

Plan coverage includes:

Office Exam, X-Rays, and
(2) Cleanings Annually

****MUST USE PPO or PREMIER PROVIDER****

Family coverage is available at the rates listed below. Cross Coverage is not available.

Monthly Premium

One Party	\$ 57.00
Two Party	\$ 119.00
Three Or More	\$ 178.00

UHC DENTAL DIRECT

Plan coverage includes:

Office Exam, X-Rays and
(2) Cleanings annually

Includes Orthodontic coverage for dependents and adults. Some procedures may require copayment.

****MUST USE UHC DENTAL DIRECT PROVIDERS****

Family coverage is available at the rates listed below. Cross Coverage is not available.

Monthly Premium

One Party	\$ 57.00
Two Party	\$ 57.00
Three Or More	\$ 57.00

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

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

VISION PLAN

☐ CHECK BOX IF NO CHANGE IS REQUIRED

VISION SERVICE PLAN (VSP)

<u>Monthly Premium</u>	<u>COBRA Rate</u>	<u>Ed Code Rate*</u>
Retiree Only	\$ 18.00	\$ 18.00
Retiree and Spouse	\$ 18.00	\$ 18.00
Retiree and Family	\$ 18.00	N/A

<u>Plan Coverage</u>		
Exam	Once every 12 months	\$5 Co-Pay
Lenses	Once every 12 months	Covered in Full
Contacts	Once every 12 months	(up to \$130)
Frames	Once every 24 months	(up to \$175)

****If you are enrolled in Medical Plan C (Kaiser Permanente), your vision coverage is offered by Kaiser Permanente.****

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

FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:

SOCIAL SECURITY CARD / 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 NUMBER
☐ DOMESTIC PARTNER		F / M			
☐ SPOUSE					
☐ SON		F / M			
☐ DAUGHTER					
☐ SON		F / M			
☐ DAUGHTER					

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 7000	Effective enrollment/ change date: 01/01/2027

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

Gender ☐ M ☐ F

Spouse/domestic partner name:

Former last name (if any):

Social Security No.

Birth Date (mm/dd/yyyy)

Medical Record No.

☐ Add ☐ Delete ☐ Child

Gender ☐ M ☐ F

Dependent name:

Relationship:

Social Security No.

Birth Date (mm/dd/yyyy)

Medical Record No.

☐ Add ☐ Delete ☐ Child

Gender ☐ M ☐ F

Dependent name:

Relationship:

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.

