

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

Medicare Eligible Retiree

RETIREE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC PARTNERSHIP		
MAILING ADDRESS			☐ CHECK BOX TO INDICATE A CHANGE OF ADDRESS		
CITY	STATE	ZIP CODE	BIRTHDATE	TELEPHONE NO.	☐ MALE ☐ FEMALE ☐ NON- BINARY ☐ DECLINE TO STATE

OTHER HEALTH INSURANCE INFORMATION

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE _____
Are you or any family members covered by another group plan? ☐ NO ☐ YES _____
GROUP NAME

AETNA MEDICARE ADVANTAGE (PPO) ☐ CHECK BOX IF NO CHANGE IS REQUIRED

(Copy of Medicare Card is required)

Monthly Premiums \$0.00	Summary Medical Covered Medical Services: 100% coverage Calendar Year Deductible: \$0.00 Out-of-pocket maximum: \$0.00 SilverScript Prescription Copays vary from \$0 - \$100. Out-of-pocket maximum: \$400/calendar year
Covers medical with limited vision coverage. EAP services through Claremont EAP.	
Same coverage for in-network and out-of-network providers. Providers just need to be eligible to accept Medicare and bill Aetna.	
All Medicare-eligible family members must be enrolled in Medicare Parts A & B. Non-Medicare-eligible family members will be enrolled in Aetna Open Choice PPO (different benefits plan).	
☐ Retiree Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Retiree ☐ Delete Dependent(s) ☐ Delete Family	

KAISER SENIOR ADVANTAGE (HMO) ☐ CHECK BOX IF NO CHANGE IS REQUIRED

(Requires Kaiser Group Enrollment and Senior Advantage forms be completed)

Monthly Premiums \$0.00	Summary Medical Covered Medical Services: 100% coverage after applicable copay Calendar Year Deductible: \$0.00 Out-of-pocket maximum: \$ 1,000.00 Prescription Copays vary from \$10 - \$35.
Covers medical, prescription, vision, and acupuncture coverage. Chiropractic care through SimpleTherapy and EAP services through Claremont EAP.	
Covered services must be obtained by a Kaiser facility/provider (except in emergencies).	
All Medicare-eligible family members must be enrolled in Medicare Parts A & B. Non-Medicare-eligible family members will be enrolled in Kaiser Deductible HMO (different benefits plan).	
☐ Retiree Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Retiree ☐ Delete Dependent(s) ☐ Delete Family	

AETNA COMMERCIAL PPO PLAN A
(Copy of Medicare Card is required)

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

Monthly Premium \$0.00

Office Visit Co-Pay \$15.00

Covered Services

Calendar Year Deductible

Medical Annual Out-Of-Pocket Max

SilverScript Prescription

PPO Providers

100% of Aetna PPO Rate

\$250 Individual / \$500 Family

\$2,100 Individual / \$4,200 Family

Copays vary from \$0 - \$100

Out-of-pocket maximum: \$400/calendar year

Non-PPO Providers

60% of UCR*

\$750 Individual / \$1,500 Family

\$10,000 Individual / \$20,000 Family

*Usual, Customary and Reasonable

All Medicare-eligible family members must be enrolled in Medicare Parts A & B. Aetna Commercial PPO A is secondary to Medicare. Aetna Commercial PPO A will be primary to non-Medicare-eligible family members.

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

AETNA COMMERCIAL PPO PLAN B
(Copy of Medicare Card is required)

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

Monthly Premium \$0.00

Office Visit Co-Pay \$25.00

Covered Services

Calendar Year Deductible

Medical Annual Out-Of-Pocket Max

SilverScript Prescription

PPO Providers

80% of Aetna PPO Rate

\$1,000 Individual / \$2,000 Family

\$5,700 Individual / \$11,400 Family

Copays vary from \$0 - \$100

Out-of-pocket maximum: \$400/calendar year

Non-PPO Providers

50% of UCR*

\$3,000 Individual / \$6,000 Family

\$12,000 Individual / \$24,000 Family

*Usual, Customary and Reasonable

All Medicare-eligible family members must be enrolled in Medicare Parts A & B. Aetna Commercial PPO B is secondary to Medicare. Aetna Commercial PPO A will be primary to non-Medicare-eligible family members.

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

OPT OUT ☐ **CHECK BOX TO OPT-OUT OF ALL MEDICAL & PRESCRIPTION COVERAGE**

By checking the box above and opting out, I affirm I do not want to be enrolled in either the Aetna Medicare Plan nor the Kaiser Senior Advantage plan. I understand that by opting out, I lose all medical and prescription coverage through the Fresno Unified School District. I understand I will only be allowed to re-enroll during the open enrollment period or if I experience a HIPAA Special Enrollment Event.

If you only want to opt-out or remove a dependent from the medical plan, please select yes in the opt-out column next to the dependent's name below.

Opting out of the medical and prescription plan will not affect your dental and/or vision coverage.

DENTAL PLANS

☐ CHECK BOX IF NO CHANGE IS REQUIRED

DELTA DENTAL PPO			UHC DENTAL DIRECT			
Maximums {	PPO	Non-PPO				
	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			Plan coverage includes: Office Exam, X-Rays, and (2) Cleanings Annually			
MUST USE PPO PROVIDER FOR PPO COVERAGE **Cross Coverage is not available**			**MUST USE UHC DENTAL DIRECT PROVIDERS** **Cross Coverage is not available**			
Monthly Premium			Monthly Premium			
	<u>COBRA Rate</u>	<u>Ed Code Rate*</u>		<u>COBRA Rate</u>	<u>Ed Code Rate*</u>	
Retiree Only	\$ 57.00	\$ 57.00	Retiree Only	\$ 57.00	\$ 57.00	
Retiree and Spouse	\$ 119.00	\$ 119.00	Retiree and Spouse	\$ 57.00	\$ 57.00	
Retiree and Family	\$ 178.00	N/A	Retiree and Family	\$ 57.00	N/A	
*Dependent child(ren) coverage is no longer provided to Retirees on ED Code 7000, effective September 1, 2013.			*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	☐ Retiree Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Retiree ☐ Delete Dependent(s) ☐ Delete Family			

VISION PLAN

☐ CHECK BOX IF NO CHANGE IS REQUIRED

VISION SERVICE PLAN (VSP)		
Monthly Premium		
	<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
Plan Coverage		
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 Kaiser Senior Advantage 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.		
☐ Retiree Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Retiree ☐ Delete Dependent(s) ☐ Delete Family		

FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF: MEDICARE CARD / 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)

	DEPENDENT NAME	GENDER	AGE	BIRTHDATE	SSN #	MEDICARE	OPT-OUT
☐ DOMESTIC PARTNER ☐ SPOUSE		☐ F ☐ M				☐ YES ☐ NO	☐ YES ☐ NO
☐ SON ☐ DAUGHTER		☐ F ☐ M				☐ YES ☐ NO	☐ YES ☐ NO
☐ SON ☐ DAUGHTER		☐ F ☐ M				☐ YES ☐ NO	☐ YES ☐ NO
☐ SON ☐ DAUGHTER		☐ F ☐ M				☐ YES ☐ NO	☐ YES ☐ NO
☐ SON ☐ DAUGHTER		☐ F ☐ M				☐ YES ☐ NO	☐ YES ☐ NO
☐ SON ☐ DAUGHTER		☐ F ☐ M				☐ YES ☐ NO	☐ YES ☐ NO

- **The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and covered dependents 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.**

RETIREE SIGNATURE _____ Date _____

Verified by:	Effective 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 0002	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 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.