

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

ED CODE PARTICIPANTS

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE 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 ☐ ED CODE
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			

MEDICAL PLAN OPTION A

☐ CHECK BOX IF NO CHANGE IS REQUIRED

<u>ED CODE MONTHLY PREMIUM</u>		
	<u>One Party</u>	<u>Two Party</u>
NON-MEDICARE UNDER 65	\$ 1,737.00	\$ 3,475.00
NON-MEDICARE OVER 65	\$ 1,392.00	\$ 2,781.00
Office Visit Co-Pay \$15.00		
Covered Services	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
Calendar Year Deductible	100% of Aetna PPO Rate	60% of UCR*
Medical Annual Out-Of-Pocket Max	\$250 Individual / \$500 Family \$2,100 Individual / \$4,200 Family	\$750 Individual / \$1,500 Family \$10,000 Individual / \$20,000 Family *Usual, Customary and Reasonable
☐ Retiree Only	☐ Add Spouse	☐ Delete Retiree
		☐ Delete Spouse

MEDICAL PLAN OPTION B

☐ CHECK BOX IF NO CHANGE IS REQUIRED

<u>ED CODE MONTHLY PREMIUM</u>		
	<u>One Party</u>	<u>Two-Party</u>
NON-MEDICARE UNDER 65	\$1,546.00	\$3,096.00
NON-MEDICARE OVER 65	\$1,250.00	\$2,495.00
Office Visit Co-Pay \$25.00		
Covered Services	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
Calendar Year Deductible	80% of Aetna PPO Rate	50% of UCR*
Medical Annual Out-Of-Pocket Max	\$1,000 Individual / \$2,000 Family \$5,700 Individual / \$11,400 Family	\$3,000 Individual / \$6,000 Family \$12,000 Individual / \$24,000 Family *Usual, Customary and Reasonable
☐ Retiree Only	☐ Add Spouse	☐ Delete Retiree
		☐ Delete Spouse

AETNA MEDICARE ADVANTAGE (PPO) ☐ CHECK BOX IF NO CHANGE IS REQUIRED*(Copy of Medicare Card is required)***ED CODE MONTHLY PREMIUM****MEDICARE RETIREE AND/OR SPOUSE OVER 65
RETIREE AND SPOUSE OVER/UNDER 65**

<u>One Party</u>	<u>Two Party</u>
\$ 512.17	\$ 1,025.42
	\$ 2,056.16

Covers medical and prescription coverage, 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 agree to see you as a patient.

Summary**Medical:**

- Covered Medical Services: **100% coverage**
- Calendar Year Deductible: **\$0.00**
- Out-of-pocket maximum: **\$0.00**

SilverScript Prescription Drugs:

- Co-pays vary from **\$0 - \$100**.
- Out-of-pocket maximum: **\$400/calendar year**

☐ Retiree Only ☐ Add Spouse ☐ Delete Retiree ☐ Delete Spouse

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).

MEDICAL PLAN OPTION C**☐ CHECK BOX IF NO CHANGE IS REQUIRED****KAISER PERMANENTE HEALTH PLAN and KAISER SENIOR ADVANTAGE**

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). If one spouse is Medicare age, a separate KAISER SENIOR ADVANTAGE FORM (Group Election Request Form) must also be completed.

ED CODE MONTHLY PREMIUM

	<u>One Party</u>	<u>Two Party</u>
NON-MEDICARE RETIREE AND/OR SPOUSE UNDER 65 (Commercial)	\$1,116.61	\$2,233.22
MEDICARE RETIREE AND/OR SPOUSE OVER 65 (KSA)	\$323.52	\$647.04
RETIREE AND SPOUSE OVER/UNDER 65 (KSA/Commercial)		\$1,440.13

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

	☐ <u>Kaiser Commercial</u>	☐ <u>Kaiser Senior Advantage (Medicare A & B required)</u>
Copay	\$15.00	
Covered Services	100% after Deductible	100% after applicable co-pay
Calendar Year Deductible	\$250 Individual / \$500 Family	\$0
Annual Out-Of-Pocket Maximum	\$2,500 Individual / \$5,000 Family	\$1,000/calendar year

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 benefits, as well as Acupuncture benefits.

☐ Retiree Only ☐ Add Spouse ☐ Delete Retiree ☐ Delete Spouse

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

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

ED CODE MONTHLY PREMIUM

<u>One Party</u>	<u>Two Party</u>
\$ 448.00	\$ 896.00

Office Visit Co-Pay \$15.00

Covered Services
Calendar Year Deductible
Medical Annual Out-Of-Pocket Max

PPO Providers

100% of Aetna PPO Rate
\$250 Individual / \$500 Family
\$2,100 Individual / \$4,200 Family

Non-PPO Providers

60% of UCR*
\$750 Individual / \$1,500 Family
\$10,000 Individual / \$20,000 Family
*Usual, Customary and Reasonable

SilverScript Prescription

Copays vary from \$0 - \$100
Out-of-pocket maximum: \$400/calendar year

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 Spouse ☐ Delete Retiree ☐ Delete Spouse

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

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

ED CODE MONTHLY PREMIUM

<u>One Party</u>	<u>Two-Party</u>
\$403.00	\$804.00

Office Visit Co-Pay \$25.00

Covered Services
Calendar Year Deductible
Medical Annual Out-Of-Pocket Max

PPO Providers

80% of Aetna PPO Rate
\$1,000 Individual / \$2,000 Family
\$5,700 Individual / \$11,400 Family

Non-PPO Providers

50% of UCR*
\$3,000 Individual / \$6,000 Family
\$12,000 Individual / \$24,000 Family
*Usual, Customary and Reasonable

SilverScript Prescription

Copays vary from \$0 - \$100
Out-of-pocket maximum: \$400/calendar year

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 Spouse ☐ Delete Retiree ☐ Delete Spouse

DENTAL PLANS

☐ CHECK BOX IF NO CHANGE IS REQUIRED

DELTA DENTAL PPO	UHC DENTAL DIRECT																
Maximums <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td> Per patient per calendar year Dental Accident per calendar year Orthodontic lifetime maximum </td> <td> PPO \$2,500 \$1,000 50% up to \$2000 </td> <td> Non-PPO \$1,500 \$1,000 </td> </tr> </table> **MUST USE PPO or PREMIER PROVIDER** Plan coverage includes: Office Exam, X-Rays, and (2) Cleanings Annually *Dependent child(ren) coverage is no longer provided to Retirees on ED Code 7000, effective September 1, 2013. Monthly Premiums <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;"><u>Ed Code Rate*</u></td> </tr> <tr> <td>One Party</td> <td style="text-align: center;">\$57.00</td> </tr> <tr> <td>Two Party</td> <td style="text-align: center;">\$119.00</td> </tr> </table> ☐ Retiree Only ☐ Add Spouse ☐ Delete Retiree ☐ Delete Spouse	{	Per patient per calendar year Dental Accident per calendar year Orthodontic lifetime maximum	PPO \$2,500 \$1,000 50% up to \$2000	Non-PPO \$1,500 \$1,000		<u>Ed Code Rate*</u>	One Party	\$57.00	Two Party	\$119.00	UHC DENTAL DIRECT Includes Orthodontic coverage for dependents and adults. Some procedures may require copayment. Plan coverage includes: Office Exam, X-Rays, and (2) Cleanings Annually **MUST USE UHC DENTAL DIRECT PROVIDERS** *Dependent child(ren) coverage is no longer provided to Retirees on ED Code 7000, effective September 1, 2013. Monthly Premiums <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;"><u>Ed Code Rate*</u></td> </tr> <tr> <td>One Party</td> <td style="text-align: center;">\$57.00</td> </tr> <tr> <td>Two Party</td> <td style="text-align: center;">\$57.00</td> </tr> </table> ☐ Retiree Only ☐ Add Spouse ☐ Delete Retiree ☐ Delete Spouse		<u>Ed Code Rate*</u>	One Party	\$57.00	Two Party	\$57.00
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VISION PLAN

☐ CHECK BOX IF NO CHANGE IS REQUIRED

VISION SERVICE PLAN (VSP)																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">Monthly Premium</th> <th style="text-align: left;">Ed Code Rate*</th> </tr> <tr> <td>Retiree Only</td> <td>\$ 18.00</td> </tr> <tr> <td>Retiree and Spouse</td> <td>\$ 18.00</td> </tr> <tr> <td>Retiree and Family</td> <td>N/A</td> </tr> </table>	Monthly Premium	Ed Code Rate*	Retiree Only	\$ 18.00	Retiree and Spouse	\$ 18.00	Retiree and Family	N/A	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: left;">Plan Coverage</th> </tr> <tr> <td>Exam</td> <td>Once every 12 months</td> <td>\$5 Co-Pay</td> </tr> <tr> <td>Lenses</td> <td>Once every 12 months</td> <td>Covered in Full</td> </tr> <tr> <td>Contacts</td> <td>Once every 12 months</td> <td>(up to \$130)</td> </tr> <tr> <td>Frames</td> <td>Once every 24 months</td> <td>(up to \$175)</td> </tr> </table>	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)
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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.																								

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 ☐ SPOUSE		F / M			

- 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.

EMPLOYEE SIGNATURE _____ Date _____

Verified by:	Effective Date:
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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 0001 Early Retiree 0002 Medicare Retiree	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.