Keyes Union Elementary School District
Part time and Substitute Benefit Selection Sheet

This plan is only available to less than 50% employees and Substitutes.

Effective Date: ***October 1, 2017 through September 30,2018***

Print Name:	Employee ID #:
Address:	Phone Number:
Hire Date:	

*You may elect to participate in this plan within **2 weeks** of your hire date or during the Annual Open Enrollment Period*

Calendar-Year Deductible : (individual / family) For an individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met	$5,000 / $10,000
Calendar-Year Maximum Co-pays (individual / family) For an individual on family coverage plan enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met	$6,350 / $12,700 Includes deductible
Physician Office Visits/Specialist Office Visit (Does not apply to calendar year maximum)	$60 per visit (for 1st -3rd visit) thereafter 30% ($60 per visit not subject to deductible)
Preventive Care	No charge deductible waived
Room & Board Hospital Inpatient (semi-private)	30% after deductible
Outpatient Surgery	30% after deductible
Emergency Room Services	$100 co-pay +30%if not admitted. 30% if admitted
Prescription Drug Deductible	*$5,000 medical deductible must be met before RX co-pays apply*
Prescription Drugs - Retail	$9 G / $35 B up to a 30 day supply
Prescription Drugs - Mail Order	$18 G / $90 B up to a 90 day supply

Please indicate your choice of coverage. PROPER FORMS must be completed and VERIFCATION provided (Birth Certificate, , Court Document of Guardianship) when dependents are added or deleted

	Classification	Monthly Premium	Codes	Select One
Blue Shield PPO 2-Tier Bronze	**Employee Only**	**$554**	**4187/6ES**	
Blue Shield PPO 2-Tier Bronze	**Employee-Child(ren)**	**$1,096**	**4187/6EF**	

Total Due Each Month _____

I accept financial responsibility for the entire cost of this benefit and authorize the Keyes Union School District to deduct from my salary warrant any payroll deduction necessary for those selections shown above.

If I am not receiving pay prior to the month of coverage I agree to pay by the 15th of the month PRIOR to the month of coverage. I will be automatically terminated if payment is not received by the 5th of the month following the month of coverage and I will not be eligible for reinstatement until the next open enrollment period.

_____ _____

Signature *Date*

Declining Coverage:

I have read and understand the notification on declining coverage. I understand that, if I decline coverage, I will be not be able to enroll in coverage until the district's Open Enrollment period for an October 1 effective date or because of one or more of the events indicated in the notification.

*I am **declining** health insurance coverage due to the following reason:* _____

_____ _____

Signature *Date*

Notification on Declining Coverage

Less Than Full Time:
If you work less than full-time and receive less than the amount that is contributed towards a full-time employee, you may decline coverage. If you decline coverage, you and your dependents will not be allowed to enroll until the Open Enrollment Period. Members who enroll during the Open Enrollment Period will become effective October 1 of the same year.

If you decline coverage and subsequently become a full-time employee or begin receiving the same contribution as a full-time employee, you must enroll in the plan the first of the month following the date of this event. If the number of hours worked increases or payment of coverage by your school district increases, you may choose to enroll the first of the month following the date of that occurrence.

Other Coverage:
If you are an employee as of January 01, 2012 you may elect to decline coverage in the event you have other Group coverage. **(Full time employees hired after January 01, 2012 may not decline coverage.)** If you are declining coverage for you and your dependent(s) because you and/or your dependents have coverage elsewhere and you subsequently lose coverage, you may enroll yourself or your dependents immediately provided you notify the district within 30 days of loss of coverage. Effective April 1, 2009 loss of coverage under a Medicaid plan, loss of coverage under Children's Health Insurance Program (CHIP) or eligibility to participate in a premium assistance program under Medicaid or CHIP gives rise to special enrollment rights. You must notify the district within 60 days of loss of coverage or becoming eligible for premium assistance. You must submit a completed and signed enrollment or change form along with a copy of the Certificate of Coverage from the "coverage elsewhere" or evidence of loss of coverage elsewhere.

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placed in your home as a result of court ordered custody or guardianship, you may enroll yourself and your dependents, provided you request enrollment within 30 days following the date of this event. Again, you must submit a completed and signed enrollment or change form.

If you fail to notify your employer that your dependent(s) is no longer eligible for coverage under your plan, they may not be eligible for continuation coverage under the COBRA or CalCOBRA law.