MT DIABLO UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES
BENEFITS OFFICE
1936 Carlotta Drive, Room 18, Concord, CA 94519
(925) 682-8000 Ext. 4452
benefits@mdusd.org

2026 COBRA MEDICAL RATES

2026 COBRA MONTHLY MEDICAL RATES RATES ARE CALCULATED AT 102%			
PLAN NAME	**1 PARTY**	**2 PARTY**	**FAMILY** (3 or more dependents)
ANTHEM SELECT HMO	$1,363.02	$2,726.03	$3,543.84
ANTHEM TRADITIONAL HMO	$1,644.32	$3,288.64	$4,275.24
BLUE SHIELD ACCESS+ HMO	$1,327.99	$2,655.98	$3,452.77
BLUE SHIELD TRIO HMO	$1,189.91	$2,379.82	$3,093.77
KAISER PERMANENTE HMO	$1,192.24	$2,384.47	$3,099.82
PERS GOLD PPO	$1,142.99	$2,285.98	$2,971.78
PERS PLATINUM PPO	$1,703.54	$3,407.09	$4,429.21
UNITED HEALTHCARE SignatureValue Alliance	$1,315.86	$2,631.72	$3,421.24
UNITED HEALTHCARE SignatureValue Harmony	$1,155.75	$2,311.50	$3,004.95
WESTERN HEALTH ADVANTAGE HMO	$988.97	$1,977.94	$2,571.33

DELTA DENTAL AND VISION SERVICE PLAN (VSP)

2026 COBRA MONTHLY DENTAL AND VISION RATES			
PLAN NAME	**1 PARTY**	**2 PARTY**	**FAMILY** (3 or more dependents)
DENTAL	$45.53	$91.07	$142.06
DENTAL PREMIUM	$56.75	$113.53	$177.07
VISION	$5.44	$10.33	$14.73

State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Group Continuation Coverage Consolidated Omnibus Budget Reconciliation Act (COBRA)

Instructions for completing this form are on page 3.

Section 1: Enrollee Information

COBRA Enrollee (may be different than subscriber)

COBRA Enrollee (First Name) (Middle Initial) (Last Name) **Birth Date** (mm/dd/yyyy)

CalPERS ID or Social Security Number (SSN)

Gender: ○ **Male** ○ **Female** ○ **Non-Binary**

Mailing Address (Street) **City** **State** **ZIP Code** **Primary Phone Number**

CalPERS Subscriber (Employee) if different from enrollee

Subscriber Name (First Name) (Middle Initial) (Last Name) **CalPERS ID or SSN**

Section 2: Type of Action

○ **New Enrollment** ○ **Add or Delete Dependent(s)** ○ **Change Health Plan** ○ **Cancel Coverage**

Section 3: Type of Permitting Event

○ **Employment Separation or Time Base Reduction** ○ **Divorce or Legal Separation** ○ **Death of an Employee**

○ **Child Ceases to be a Dependent** ○ **Dependent Eligibility Verification**

○ **Dependent Continuation – Original Enrollee Eligible for Medicare** ○ **SSA Certified Disability – 11 Month Extension**

Event Date (mm/dd/yyyy) **COBRA Enrollment Period** (mm/01/yyyy) **to** (mm/dd/yyyy)

Section 4: Dependent Information

List of all persons to be enrolled (including self).

Name (First M.I. Last)	Relationship	Birthdate (mm/dd/yyyy)	CalPERS ID or SSN	Action	Health/ Dental Changes
	Self			○ Add ○ Delete	☐ Health ☐ Dental
				○ Add ○ Delete	☐ Health ☐ Dental
				○ Add ○ Delete	☐ Health ☐ Dental
				○ Add ○ Delete	☐ Health ☐ Dental

Section 5: Plan Information

Health Plan

Section 6: Signature of Enrollee

I agree to pay the premium for the coverage directly to the plan listed in Section 5. I understand that I am required to make the initial payment within 45 days of election to enroll and agree to make future payments in a timely manner as required by the plan(s). I understand that failure to pay the premium will result in automatic termination of coverage. I certify that the information provided by me is true and correct to the best of my knowledge and ability.

Signature of COBRA Enrollee (see attachment for privacy Information) **Date Signed** (mm/dd/yyyy)

Submit this form to your employer

Please do not submit payment to your employer or CalPERS. You will receive payment instructions from your health plan.

Section 7: Agency Information

Agency Name **Agency Code**

Health Benefit Officer Signature **Date Received** (mm/dd/yyyy) **Primary Phone Number**

Section 8: COBRA Instructions

Section 1: Enrollee Information

a. Provide all requested information
b. Identify the employee if the COBRA enrollee is a former dependent

Section 2: Type of Action

a. Select new enrollment if this is your new/initial enrollment
    i. There cannot be a break in coverage between the end of CalPERS active health coverage and the beginning of COBRA enrollment
b. Select add or delete dependent if you are adding or deleting a dependent
c. Select change health plan if you are changing your health plan
d. Select cancel if you are canceling your COBRA enrollment
    i. If cancel is selected, continue to Section 4

Section 3: Type of Permitting Event

a. Select the appropriate permitting event
b. Provide original event date (permanent separation, divorce date, ect.)
c. Enter COBRA enrollment period (18 or 36 months depending on permitting event)
    i. Example: Permanent Separation date is 4/15/2023 (COBRA Enrollment Period: From 6/1/2023 to 11/30/2024)
    ii. Example: Child attains age 26 on 06/15/2023 (COBRA Enrollment Period: From 07/01/2023 to 06/30/2026)

Section 4: Dependent Information

a. List all dependents to be enrolled, including self (if applicable)
    i. Enter dependent's name, relationship, birthdate, and CalPERS ID number or Social Security Number
    ii. Select applicable action to add if the dependent is being added or newly enrolled
    iii. Select applicable action to delete if the dependent is being deleted from COBRA coverage
    iv. An action is not required when changing carriers
    v. Check Health and/ or Dental to indicate election based on the action
        i. The addition and deletion of dependent is regulated by time limits, which are identical for active employees.

Section 5: Plan Information

a. Complete fields

Section 6: Signature of Enrollee

a. Signature of COBRA enrollee and date signed

Section 7: Agency Information

a. Completed by the current or former employing agency's Health Benefit Officer/ Personnel Office. CalPERS is the employing agency for former departments of retirees.

Important

It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws and time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Section 7.

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested by CalPERS' Information Security Office is collected pursuant to the following authority:

- CA Civil Code §56.10
- CA Civil Code §56.11
- CA Civil Code §56.13
- 45 C.F.R. §164.508

The principal purpose the information will be used for is the administration of duties under the Health Insurance Portability and Accountability Act (HIPAA), as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to process your request.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers (SSN) are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided to CalPERS, disclosure is voluntary. Due to the use of SSNs by other agencies for identification purposes, we may be unable to process your request without its disclosure.

Social Security numbers are used for the following purposes:

1. Member / Representative identification
2. Fulfill Member / Representative requests

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy (https://www.calpers.ca.gov/page/privacy-policy), or your rights, please write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).

MT. DIABLO UNIFIED SCHOOL DISTRICT
Office of General Counsel
Benefits Office
(925) 682-8000 x 4152
benefits@mdusd.org

Effective Date: _____

Termination Date: _____

Employee and Dependents

Dental

COBRA Continuation Election

If you wish to purchase continued Delta Dental coverage under the Consolidated Omnibus Reconciliation Act (COBRA), please complete this form and return it to the Mt. Diablo Unified School District ("District") Benefits Office **no later than 60 days from the date your coverage ends.** Failure to return this form within the specified period of time will be considered an election against coverage. If you elect against (or are considered to have elected against) COBRA coverage for you and/or your dependents, all rights to COBRA coverage shall be forfeited. Complete the COBRA Payment Agreement on the reverse side and follow the instructions for payments.

Employee Name (Please Print)		Employee ID and/or Social Security Number
Employee Street Address		❑ Male **OR** ❑ Female
Employee City and Zip Code		Employee Date of Birth
Employee **Cell** Phone Number	Employee **Home** Phone Number	Employee Email Address

I elect to enroll myself and eligible dependents listed below in COBRA. Please check ALL boxes that apply and note length of COBRA coverage:

❑ Reduction in Hours and Lost Benefits (18 months)
❑ Separation of Employment-Resignation (18 months)
❑ I am 65 (Medicare Age) or Older (36 months even if reason is checked above)

❑ Delta Dental 1-Party **$45.53** – monthly rate	❑ Premium Dental 1-Party **$56.75** – monthly rate
❑ Delta Dental 2-Party **$91.07** – monthly rate	❑ Premium Dental 2-Party **$113.53** – monthly rate
❑ Delta Dental Family (3+) **$142.06** – monthly rate	❑ Premium Dental 3-Party **$177.07** – monthly rate

If you are continuing coverage for any dependents, list their name(s), relationship and date of birth.

Dependent Name	Relationship	Date of Birth
	❑Child under Age 26 ❑Spouse ❑Domestic Partner	
Dependent Name	Relationship	Date of Birth
	❑Child under Age 26 ❑Spouse ❑Domestic Partner	
Dependent Name	Relationship	Date of Birth
	❑Child under Age 26 ❑Spouse ❑Domestic Partner	

Are you enrolled in Medicare?

❑ No ❑ Yes, I was entitled to Medicare as of _____ (1st day of the month you turned 65)

Are you currently disabled according to the Social Security Administration (*skip this section, sign, and date below if this is not applicable to you*). If you have been determined by the Social Security Administration to have been disabled on the date of termination of benefits, you may be eligible to extend your COBRA benefits for a maximum of 29 months instead of 18 months. ***If your loss of coverage already allows you to receive 36 months of COBRA benefits,*** that would be the maximum so ***do not complete this section.*** You must notify the Benefits office within the first 60 days of COBRA coverage if you are determined disabled by the Social Security Administration.

❑ Yes, I am disabled. ❑ No, I have not yet been determined disabled by the Social Security Administration but in the process.

If in the process of Social Security determination of disability, I understand I must notify the District Benefits office within 60 days of the Social Security determination (while enrolled in COBRA) to extend my COBRA up to a maximum of 29 months.

Applicant's Signature: _____ *Date:* _____

COBRA PAYMENT AGREEMENT for DENTAL COVERAGE

Copies Sent To:

❑ Fiscal _____
❑ Employee_____

I hereby request that the Mt. Diablo Unified School District make premium payments on my behalf for my group insurance coverage for Dental benefits as requested on the reverse side of this form. I understand that in order to continue my coverage, I must fulfill the following conditions:

1. Checks are made **payable to:** **MDUSD**

2. Checks are **mailed to:** Mt. Diablo Unified School District
Fiscal Services Department
1936 Carlotta Drive
Concord, CA 94519-1397

Your initial payment with the enrollment form is mailed/delivered to the Benefits Office with both sides of this form completed. Once billing begins from the Fiscal Services Department, all premiums will then be mailed to the Fiscal Services Department.

3. All premiums must be paid one (1) month in advance. If payment is not received by Fiscal Services by the due date, coverage will be canceled. You may pay several months in advance. Be sure to include a separate note or a note on your check if you are paying for more than one (1) month.

4. Premiums **must be received** by Fiscal Services **no later than the 10th of the month** preceding the period in which coverage is to continue (for example, for August coverage, payment must be received in Fiscal Services by July 10th).

Fill out name/address where invoices are to be mailed **(please print):**

NAME: _____

ADDRESS: _____

_____

PHONE/EMAIL: _____

I understand that my Dental coverage will be canceled if Fiscal Services does not receive payment by the 10th of the month prior to coverage continuing. **I understand coverage will not be reinstated once it has been canceled due to nonpayment.**

_____ _____

Signature *Date*

MT. DIABLO UNIFIED SCHOOL DISTRICT
Office of General Counsel
Benefits Office
(925) 682-8000 x 4152
benefits@mdusd.org

Effective Date:
_____
Termination Date:
_____

Employee and Dependents

VSP Vision

COBRA Continuation Election

If you wish to purchase continued VSP Vision care coverage under the Consolidated Omnibus Reconciliation Act (COBRA), please complete this form and return it to the Mt. Diablo Unified School District ("District") Benefits Office **no later than 60 days from the date your coverage ends**. Failure to return this form within the specified period of time will be considered an election against coverage. If you elect against (or are considered to have elected against) COBRA coverage for you and/or your dependents, all rights to COBRA coverage shall be forfeited. Complete the COBRA Payment Agreement on the reverse side and follow the instructions for payments.

Employee Name (Please Print)		Employee ID and/or Social Security Number
Employee Street Address		❑ Male **OR** ❑ Female
Employee City and Zip Code		Employee Date of Birth
Employee **Cell** Phone Number	Employee **Home** Phone Number	Employee Email Address

I elect to enroll myself and eligible dependents listed below in COBRA. Please check ALL boxes that apply and note length of COBRA coverage:

❑ Reduction in Hours and Lost Benefits (18 months)
❑ Separation of Employment (resign, retire, etc.) (18 months)
❑ I am 65 (Medicare Age) or Older (36 months even if reason is checked above)

❑ VSP Vision 1-Party **$5.44** – monthly rate
❑ VSP Vision 2-Party **$10.33** – monthly rate
❑ VSP Vision Family (3+) **$14.73** – monthly rate

If you are continuing coverage for any dependents, list their name(s), relationship and date of birth.

Dependent Name	Relationship ❑Child under Age 26 ❑Spouse ❑Domestic Partner	Date of Birth
Dependent Name	Relationship ❑Child under Age 26 ❑Spouse ❑Domestic Partner	Date of Birth
Dependent Name	Relationship ❑Child under Age 26 ❑Spouse ❑Domestic Partner	Date of Birth

Are you enrolled in Medicare?
❑ No ❑ Yes, I was entitled to Medicare as of _____ (1st day of the month you turned 65)

Are you currently disabled according to the Social Security Administration (*skip this section, sign, and date below if this is not applicable to you*). If you have been determined by the Social Security Administration to have been disabled on the date of termination of benefits, you may be eligible to extend your COBRA benefits for a maximum of 29 months instead of 18 months. ***If your loss of coverage already allows you to receive 36 months of COBRA benefits,*** that would be the maximum so ***do not complete this section.*** You must notify the Benefits office within the first 60 days of COBRA coverage if you are determined disabled by the Social Security Administration.

❑ Yes, I am disabled. ❑ No, I have not yet been determined disabled by the Social Security Administration but in the process.

If in the process of Social Security determination of disability, I understand I must notify the District Benefits office within 60 days of the Social Security determination (while enrolled in COBRA) to extend my COBRA up to a maximum of 29 months.

Applicant's Signature: _____ *Date:* _____

COBRA PAYMENT AGREEMENT for VSP VISION COVERAGE

Copies Sent To:

❑ Fiscal _____
❑ Employee_____

I hereby request that the Mt. Diablo Unified School District make premium payments on my behalf for my group insurance coverage for VSP Vision benefits as requested on the reverse side of this form. I understand that in order to continue my coverage, I must fulfill the following conditions:

1. Checks are made **payable to:** **MDUSD**

2. Checks are **mailed to:** Mt. Diablo Unified School District
Fiscal Services Department
1936 Carlotta Drive
Concord, CA 94519-1397

Your initial payment with the enrollment form is mailed/delivered to the Benefits Office with both sides of this form completed. Once billing begins from the Fiscal Services Department, all premiums will then be mailed to the Fiscal Services Department.

3. All premiums must be paid one (1) month in advance. If payment is not received by Fiscal Services by the due date, coverage will be canceled. You may pay several months in advance. Be sure to include a separate note or a note on your check if you are paying for more than one (1) month.

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Fill out name/address where invoices are to be mailed **(please print):**

NAME: _____

ADDRESS: _____

_____

PHONE/EMAIL: _____

I understand that my VSP Vision coverage will be canceled if Fiscal Services does not receive payment by the 10th of the month prior to coverage continuing. **I understand coverage will not be reinstated once it has been canceled due to nonpayment.**

_____ _____

Signature ***Date***