OPEN ENROLLMENT BENEFITS SCHEDULE
Certificated – 2020-2021 Rates

Geyserville Unified School District

- Open enrollment for benefits for all staff is from August 1 to August 31 each year.
- Benefit rates and coverage are from October 1 through September 30 each year.
- The District Cap applies to the total rate of benefits taken. (Medical + Vison + Dental + Life)
- All full-time employees MUST select a coverage plan.
For full-time, certificated employees, the District will contribute the following amounts per month (District Cap):

Employee	**$455.46/mo.**	**$5,465.51/yr.**
Employee + 1	**$813.01/mo.**	**$9,756.17/yr.**
Family	**$1,064.16/mo.**	**$12,769.95/yr.**

Kaiser

	KN2-Active	KN4-Active	KN1 Wellness Active
Employee	$1,035	$1,002	$816
Employee + 1	$1,779	$1,722	$1,402
Family	$2,244	$2,172	$1,769

PPO – Anthem Blue Cross

	PPO 2, RX-B	PPO 4, RX-B	PPO 7, RX-C	PPO 10, RX-D	CVT PPO Bronze
Employee	$1,063	$991	$893	$596	$514
Employee + 1	$1,828	$1,705	$1,536	$1,025	$884
Family	$2,306	$2,150	$1,937	$1,293	$1,115

Vision - VSP

Employee	$9.73
Employee + 1	$19.25
Family	$27.20

Delta Dental

Employee Only	$50.00
Employee + 1	$90.00
Family	$131.00

Life Insurance

Composite Rate	$7.29

2020 – 2021 Open Enrollment Form – *Certificated*

Instructions→ Please complete and/or mark below all options that you are selecting. ***See other side for Benefits Schedule (rates).***
If you are not making changes to your current plan, please mark **NO CHANGES.**
All employees must complete the Open Enrollment form each year.
You MUST indicate a choice or no changes. Print name, sign and date at the bottom where indicated.

I will be covering→

☐ Myself: _____
Name Date of birth

☐Spouse: _____
Name Date of birth

☐ Dependent: _____
Name Date of birth

☐ Dependent: _____
Name Date of birth

☐ Dependent: _____
Name Date of birth

☐ Dependent: _____
Name Date of birth

Health Provider Selection→

_____**Kaiser** ☐ KN2-Active ☐ KN4-Active ☐ KN1 Wellness

_____**PPO - Anthem Blue Cross** ☐ PPO 2, RX-B ☐ PPO 7, RX-C ☐CVT PPO Bronze
☐ PPO 4, RX-B ☐ PPO 10, RX-D

I am also selecting→ ☐ Dental ☐ Vision ☐ Life (Full-time employees MUST choose all three.)

NO CHANGES TO PLAN ☐

Employee Name: _____ Signature: _____ Date: _____