OPEN ENROLLMENT BENEFITS SCHEDULE
Classified - 2019-2020 Rates

- 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)

For full-time, classified employees, the District will contribute the following amounts per month (District Cap):

Employee	**$441.08/mo**	**$5,292.96/yr**
Employee + 1	**$787.26/mo**	**$9,448.16/yr**
Family	**$1,035.56/mo**	**$12,366.79/yr**

Kaiser

	Traditional HMO $10/$10Rx	**Traditional HMO $20/$10-$20Rx**	**$500 Deductible HMO**	**High Deductible HSA Eligible**
Employee	$788	$771	$669	$493
Employee + 1	$1,553	$1,648	$1,430	$1,054
Family	$2,135	$2,266	$1,966	$1,450

PPO

	100% Plan B	**90 % Plan E**	**80% Plan G**	**High Deductible HSA Eligible**	**2-Tier Anchor Plan B**
Employee	$844	$771	$681	$516	$463
Employee + 1	$1,789	$1,627	$1,438	$1,135	N/A
Family	$2,489	$2,261	$1,998	$1,599	$1.010

Vision - VSP

Employee	$9.73
Employee + 1	$19.25
Family	$27.20

Delta Dental

Composite Rate	$115.00

Life Insurance

Composite Rate	$7.29

2019 – 2020 Open Enrollment Form – *Classified*

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** ☐Traditional HMO ($10/$10Rx) ☐$500 Deductible HMO
☐Traditional HMO ($20/$10-$20Rx) ☐High Deductible, HSA Eligible

_____**PPO - Anthem Blue Cross** ☐100% Plan B ☐90% Plan E ☐80% Plan G
☐High Deductible HAS Eligible ☐2-Tier Anchor Plan B

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

NO CHANGES TO PLAN ☐

Employee Name: _____ Signature: _____ Date: _____