OPEN ENROLLMENT BENEFITS SCHEDULE
Classified – 2022-2023 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)**
- **All full-time employees MUST select a coverage plan.**

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

Employee	**$625/mo.**	**$7,500/yr.**
Employee + 1	**$1,000/mo.**	**$12,000/yr.**
Family	**$1,210/mo.**	**$14,520/yr.**

Kaiser

	Traditional HMO $10/$10Rx	**Traditional HMO $20/$10-$20Rx**	**$500 Deductible HMO**	**High Deductible HSA Eligible**
Employee	$919	$899	$778	$574
Employee + 1	$1,910	$1,897	$1,641	$1,210
Family	$2,693	$2,634	$2,279	$1,681

PPO

	100% Plan B	**90 % Plan E**	**80% Plan G**	**High Deductible HSA Eligible**	**2-Tier Anchor Plan B**
Employee	$900	$821	$726	$551	$495
Employee + 1	$1,910	$1,736	$1,535	$1,213	$1,080
Family	$2,660	$2,415	$2,135	$1,709	$1,080

Vision - VSP

Employee	$8.73
Employee + 1	$18.25
Family	$26.20

Delta Dental

Composite Rate $115.00

Life Insurance

Composite Rate $7.29

2022 - 2023 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: _________________________