OPEN ENROLLMENT BENEFITS SCHEDULE

Certificated – 2026-2027 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 + Vision + Dental + Life)**
- **All full-time employees MUST select a coverage plan.**

For unit members hired before July 1, 2023, the cap applied to an individual employee will be determined strictly by the number of family members that employee would be eligible to cover, instead of the number actually covered. Unit members hired on or after July 1, 2023 shall be eligible for District contribution toward health, dental, and vision premiums based on the level of health coverage the unit member elects.

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

Employee	**$750/mo.**	**$9,000/yr.**
Employee + 1	**$1,125/mo.**	**$13,500/yr.**
Family	**$1,335/mo.**	**$16,020/yr.**

Kaiser

	KN HMO2-Active	KN HMO4-Active	KN1 HMO Wellness Active
Employee	$1487	$1439	$1220
Employee + 1	$2557	$2475	$2097
Family	$3223	$3122	$2645

PPO – Anthem Blue Cross

	PPO 2, RX-B	PPO 4, RX-B	PPO 7, RX-C	PPO 10, RX-D	CVT PPO Bronze
Employee	$1601	$1492	$1346	$899	$760
Employee + 1	$2754	$2566	$2315	$1545	$1308
Family	$3475	$3237	$2920	$1950	$1650

Vision - VSP

Employee	$8
Employee + 1	$16
Family	$23

Delta Dental

Employee Only	$48.00
Employee + 1	$87.00
Family	$126.00

Life Insurance

Composite Rate	$7.29

2026 – 2027 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: _____