OPEN ENROLLMENT BENEFITS SCHEDULE

Classified – 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 (4 PLANS)

	Traditional HMO $10/$10Rx	**Traditional HMO $20/$10-$20Rx**	**$500 Deductible HMO**	**High Deductible HSA Eligible**
Employee	$1269	$1241	$1097	$809
Employee + 1	$2679	$2620	$2314	$1707
Family	$3720	$3638	$3213	$2370

PPO (6 PLANS)

	100% Plan B	**90 % Plan E**	**80% Plan G**	**High Deductible**	**NEW! SISC ProActive PPO**	**2-Tier HSA Eligible**
Employee	$1207	$1113	$978	$746	$781	**Employee Only** $679
Employee + 1	$2565	$2358	$2069	$1560	$1634	no coverage for spouse
Family	$3571	$3278	$2877	$2161	$2264	**Employee+Child** $1402

Vision - VSP

Employee	$8
Employee + 1	$16
Family	$23

Delta Dental

Composite Rate	$111.00

Life Insurance

Composite Rate	$7.29

2026 - 2027 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 H
□Traditional HMO ($20/$10-$20Rx) □High Deductible, HSA Eligible

PPO - Blue Shield of CA □100% Plan B □90% Plan E □80% Plan G
□High Deductible HSA 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: _____