CERTIFICATED PERSONNEL-HEALTH & WELFARE ELECTION FORM

NEVADA COUNTY RESIDENTS

July 1, 2016 through June 30, 2017

EACH ELIGIBLE CERTIFICATED EMPLOYEE MUST COMPLETE FOR FISCAL YEAR 2016-2017

The following costs are based on the SIG rates for the 2016-2017 school year and the tiered district health & welfare cap for the 2016-2017 school year. This example is based on a 12 month pay period. The actual amounts may differ depending on a variety of circumstances including but not limited to the number of months the employee is being paid and/or the hire date of the employee (proration effective 7/1/97).

DISTRICT CONTRIBUTION	Employee Only	& Spouse	& Children	& Family
1.O FTE - 100%	$ 707.65	$ 1,008.65	$ 880.65	$ 1,085.65
4/5 FTE - 80%	$ 566.12	$ 806.92	$ 704.52	$ 868.52
3/5 - 60%	$ 424.59	$ 605.19	$ 528.39	$ 651.39

Life Insurance (covered for all eligible employees even if health insurance is waived)	$ 7.70	$ 7.70	$ 7.70	$ 7.70

PLEASE CIRCLE YOUR HEALTH PLAN CHOICE

SIG PLAN COST	Employee Only	& Spouse	& Children	& Family
Health Net High Ded PPO ($2,250/$4,500) w/HSA	$ 664.00	$ 1,328.00	$ 1,019.00	$ 1,528.00
Health Net High Ded-MID PPO($1,300/$2,600) w/HSA	$ 824.00	$ 1,648.00	$ 1,265.00	$ 1,896.00
Health Net High Ded-PPO ($5,000/$10,000) w/HSA	$ 463.00	$ 926.00	$ 710.00	$ 1,065.00
Health Net HMO	$ 1,121.00	$ 2,242.00	$ 1,715.00	$ 2,649.00

Please note: You may elect to have dental and or vision only if you elect to have health coverage. Please see reverse side for important information regarding your dental/vision plan choice.

Do you elect Dental Insurance? YES or NO (Circle)

Dental Plan-Composite Rate Employee and/or Family	$ 119.75	$ 119.75	$ 119.75	$ 119.75

Do you elect Vision Insurance? YES or NO (Circle)

Vision Plan -Composite Rate Employee and/or Family	$ 22.25	$ 22.25	$ 22.25	$ 22.25

Example of Employee only choosing HNHDP with Dental and Vision

	Employee Plan Cost Estimator	
	SIG Plan Cost	$ 664.00
	Life Ins	$ 7.70
Optional	Dental	$ 119.75
Optional	Vision	$ 22.25
	Less Dist. Cap	$ (707.65)
	Monthly Employee Deduction or (contribution to H.S.A)	$ 106.05

Please Note: If the SIG Plan Cost is less than the District Contribution, the difference will be deposited to the employee's H.S.A. account.

If an employee elects to waive their insurance, the employee must complete a Waiver-Refusal of Employee Benefit Coverage form. The Waiver-Refusal of Employee Benefit Coverage form is available at the District Office. If an employee elects to waive their insurance due to coverage from another carrier, then the employee should submit a copy of their insurance card along with the Waiver-Refusal of Employee Benefit Coverage form to the District Office. An employee who waives their insurance and does not have insurance through another carrier may not elect to sign up for benefits between open enrollment periods.

I have read the information provided about the medical plan I have selected above and I understand the benefits provided by the plan. I understand that I may choose a different plan in next year's open enrollment. These programs and their cost may change based on SIG medical plan offerings.

THIS DECISION IS IRREVOCABLE UNTIL NEXT YEAR'S OPEN ENROLLMENT.

_____I elect to keep my health benefits the same as last year

_____ I elect to make changes to my health benefits indicated above

_____ I decline all health benefits for the 2015-16 school year

_____ _____

Employee name (Signature) **Date**

_____

Employee name (Printed)

Before you opt out of the Dental and/or Vision Plan(s)

If you do opt out of dental, remember that you will lose your current percentage of payment. Should you re-enroll in the future, your reimbursement percentage will be at the 70% benefit level. Additionally, this will apply to all your dependents covered by the plan. If you have double coverage, you and your dependents will receive double the annual limits except for the cleanings.

Before you opt out of Dental remember rates are composite for the entire family at $119.75 per month:

- Check your eligibility level – 70%/80%/90%/100% for each family member
- ***If you opt out and re-enroll in the future each family member will revert to the 70% level***
- Double coverage gets double benefit except for cleanings (ie: procedures, orthodontia)
    - IE: Premium of $2,200 annual maximum with 50% orthodontia for average 4 person family cost of $1,437.
- Without dental coverage you could pay the usual and customary rate for services
    - Exam $99
    - X-rays $140
    - Cleanings $110 twice per year
    - Crown $1,160 to $1,230
    - Root canal $825 to $1,170 (usually with a crown so total of $1,925 to $2,400)
    - Extraction $197
    - Minimum for family of 4 $1,836

Before you opt out of Vision remember rates are composite for the entire family at $22.25 per month:

- Average cost of glasses and exam retail $300-$350
- Target woman's plastic frame $100 to $180 plus exam and lens
- VSP exam $115, Standard Lenses $105

Note: These fees are only a sampling from various websites. The fees charged by your provider could be higher or lower than those quoted.