CLASSIFIED PERSONNEL-HEALTH & WELFARE ELECTION FORM FOR PLACER COUNTY RESIDENTS

July 1, 2017 through June 30, 2018

EACH ELIGIBLE CLASSIFIED EMPLOYEE MUST COMPLETE FOR FISCAL YEAR 2017-2018

The following costs are based on the SIG rates for the 2017-2018 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
7 + hours 100%	$ 659.00	$ 910.00	$ 799.00	$ 974.00
6 to 6.99 hours 75%	$ 494.25	$ 682.50	$ 599.25	$ 730.50
5 to 5.99 hours 62.5%	$ 411.88	$ 568.75	$ 499.38	$ 608.75
4 to 4.99 hours 50%	$ 329.50	$ 455.00	$ 399.50	$ 487.00
Life Insurance (covered for eligible employees even if health insurance is waived)	$ 4.80	$ 4.80	$ 4.80	$ 4.80

PLEASE CIRCLE YOUR HEALTH PLAN CHOICE

SIG PLAN COST	Employee Only	& Spouse	& Children	& Family
UHC Signature Value HMO	$ 1,121.00	$ 2,242.00	$ 1,715.00	$ 2,649.00
UHC Core Essential EPO ($2,600/$4,500) w/H.S.A.	$ 743.00	$ 1,486.00	$ 1,140.00	$ 1,711.00
UHC Core Essential EPO ($5,000/$10,000) w/H.S.A.	$ 517.00	$ 1,034.00	$ 795.00	$ 1,193.00
*Kaiser HMO 0559D	$ 769.00	$ 1,538.00	$ 1,169.00	$ 1,807.00
*Kaiser 602214 ($2,000/$4,000 High Deductible) w/H.S.A.	$ 511.00	$ 1,022.00	$ 778.00	$ 1,201.00
*Sutter Health HMO	$ 738.00	$ 1,476.00	$ 1,121.00	$ 1,733.00
*Sutter Health High Ded HMO ($1,500/$3,000) w/H.S.A.	$ 523.00	$ 1,046.00	$ 796.00	$ 1,229.00
*Sutter Health High Ded HMO ($2,500/$5,000) w/H.S.A.	$ 463.00	$ 926.00	$ 705.00	$ 1,089.00
*Western Health Advantage HMO Premier 20	$ 694.00	$ 1,388.00	$ 1,054.00	$ 1,630.00
*Western Health Advantage High Ded HMO ($1,800/$3,600) w/H.S.A.	$ 525.00	$ 1,050.00	$ 797.00	$ 1,227.00
*Western Health Advantage High Ded HMO ($2,800/$5,600) w/H.S.A.	$ 443.00	$ 886.00	$ 673.00	$ 1,035.00

Service areas limited and other plan options may be available to employees living in Placer County-see district office for more information

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 UHHDP with Dental and Vision

	Employee Plan Cost Estimator	
	SIG Plan Cost	$ 743.00
	Life Ins	$ 4.80
Optional	Dental	$ 119.75
Optional	Vision	$ 22.25
	Less Dist. Cap	$ (659.00)
	Monthly Employee Deduction or (contribution to H.S.A)	$ 230.80

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 currently have a Kaiser, Sutter Health, or Western Health Advantage Plan and choose to keep the same plan for FY2017-18.

_____I have circled my choices above and completed the attached SIG enrollment form.

_____I decline all health benefits for the 2017-2018 school year and have completed the attached waiver form.

_____ _____

Employee name (Signature) **Date**

_____

Employee name (Printed)