

**PETALUMA CITY SCHOOLS (CSEA Staff)
HEALTH BENEFITS ELECTION FORM FOR OCTOBER 1, 2023 TO SEPTEMBER 30, 2024**

SECTION 1: EMPLOYEE INFORMATION		
Employee:		Employee ID:
Date:	Position / Site:	Hours / Day:

SECTION 2: ELIGIBILITY INFORMATION FOR BENEFITS EFFECTIVE: _____
<input type="checkbox"/> I have been advised of my eligibility for coverage under the District's group insurance plan as follows:
<input type="checkbox"/> I understand the District will pay up to: _____% of the medical Cap (\$1,130.13) for a health plan premium. _____% of the dental Cap (\$144.50) and/or vision plan (\$29.00). I will be responsible for the remainder of the premium and authorize the deduction(s) from my paychecks.
<input type="checkbox"/> I have been advised that any insurance I elect will remain in effect through September 30, 2024, unless I have a qualifying event.
<input type="checkbox"/> I have received the IRS Section 125 Benefit Overview.

SECTION 3: BENEFIT ELECTION(S) AND / OR WAIVER(S)
I ELECT COVERAGE UNDER THE FOLLOWING PLAN(S) (SEE REVERSE SIDE FOR DETAILED RATE INFORMATION):
<input type="checkbox"/> Blue Shield 90% PPO (\$20 OV / 10% Hospital Admit) <input type="checkbox"/> Kaiser High Package TWO (\$20 OV / \$0 Hospital Admit) <input type="checkbox"/> Blue Shield 80% PPO (\$30 OV / 20% Hospital Admit) <input type="checkbox"/> Kaiser Mid (\$500 Individual / \$1,000 Family Deductible) <input type="checkbox"/> Blue Shield HD PPO (\$3,000 Individual / \$5,200 Family Deductible) <input type="checkbox"/> Kaiser Low (\$1,500 Individual / \$3,000 Family Deductible) <input type="checkbox"/> Blue Shield Anchor Bronze (Minimum Value Plan) <input type="checkbox"/> Delta Dental (\$1,900 Calendar Year Maximum per Enrollee) <input type="checkbox"/> Vision Service Plan (\$15 OV / \$120 Frame Allowance) <input type="checkbox"/> MetLife Life Insurance (\$37,000 Policy)
I WAIVE MY RIGHTS TO BENEFITS FOR THE FOLLOWING COVERAGE(S):
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life
<i>My waiver of any benefits is made with the understanding that I will not be eligible for insurance coverage until the next open enrollment period and that such benefits would not be available until October 1, 2024, unless my coverage through another employer or government sponsored health care plan terminates as a result of any of the following qualifying events:</i>
<ul style="list-style-type: none"> • Termination of employment • Change in employment status • Termination of the other plan's coverage • Cessation of the other employer's contribution toward coverage • Divorce from the person through whom I am covered as a dependent • Termination of domestic partnership from the person through whom I am covered as a dependent • The death of the person through whom I am covered as a dependent

SECTION 4: DISCLOSURES
<input type="checkbox"/> I understand that the rate information on the next page is based on the <u>monthly</u> premium for each plan. Kaiser High Package 2, Kaiser Mid, Kaiser Low, Blue Shield 90%, Blue Shield 80% and Blue Shield HD have composite rates. Blue Shield Anchor Bronze (Minimum Value Plan) has tiered rates. I understand that my premium may vary depending on the plan I select and the number of dependent(s) enrolled on my plan.
<input type="checkbox"/> I understand that COBRA rates vary by plan and are subject to a 2% surcharge. KH-2, KM, KL, BS 90%, BS 80% and BS HD COBRA rates are based on the composite rate charged to active employees. Blue Shield Anchor Bronze (Minimum Value Plan) rates are based on the tiered rate charged to active employees.
<input type="checkbox"/> I have been advised any child(ren) may be enrolled on my insurance plan(s) until the first of the month after their 26 th birthday and that I will receive COBRA continuation of coverage information from the District's COBRA Administrator, RESIG, upon termination of his / her coverage on my plan(s).
<input type="checkbox"/> I understand that the fair market value of the health insurance coverage provided by Petaluma City Schools to cover my domestic partner and his / her child(ren) may be reported as taxable income on my W-2.
<input type="checkbox"/> I agree to notify Human Resources within 30 days of any change in my dependent(s) status due to marriage / domestic partnership, divorce / end of domestic partnership, birth / adoption, or death.
<input type="checkbox"/> I will be responsible for any claims incurred by ineligible dependents as a result of providing false information or not reporting changes within the 30 day time limit.

SECTION 5: AUTHORIZATION
<i>All information of this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan or provided by the District. I understand that I must notify Human Resources immediately of any qualifying events. Any misstatements or omissions may result in future claims being denied and / or the policy being rescinded. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the District or insurance carrier or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. The District will report all cases of fraud to the proper authorities. I attest by signing below that I have reviewed the information provided on this page and, to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.</i>
Employee Signature: _____
Date: _____

CHECKLIST					
	MEDICAL			NEED	
___ Single	___ KH-2	___ BS 90	___ Delta Dental	Verification Documents	Enrollment Forms
___ Double	___ KM	___ BS 80	___ VSP	___ Tax Returns (First Page)	___ Medical
___ Family	___ KL	___ BS HD	___ Life \$37K	___ Marriage License	___ Dental
		___ BS AB	___ Life \$18.5K (Job Share)	___ Notarized Affidavit of Marriage	___ Vision
				___ Birth Certificate(s)	___ Life
				___ SSN	

HR Initials: _____

OVER

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**PETALUMA CITY SCHOOLS (CSEA Staff)
OCTOBER 1, 2023 TO SEPTEMBER 30, 2024**

PLAN OPTIONS AND PREMIUMS - DISTRICT PAID CAP FOR FULL-TIME EMPLOYEES → \$1,130.13 PER MONTH	
"Per paycheck" calculation is for informational purposes only and does not account for late starts, October 1 st rate changes or plan changes during open enrollment. Actual "per paycheck" calculations are calculated manually by payroll and are based on the situation for the specific employee.	
Kaiser High Package 2 - \$2,161.00 monthly premium / \$1,130.13 District-paid Cap for full-time employees & qualifying family members	
100%	\$1,030.87 per month over District-paid Cap (11 paychecks per year - \$1,124.59 per paycheck)
75%	\$1,313.40 per month over District-paid Cap (11 paychecks per year - \$1,432.80 per paycheck)
Kaiser Mid - \$1,870.00 monthly premium / \$1,130.13 District-paid Cap for full-time employees & qualifying family members	
100%	\$739.87 per month over District-paid Cap (11 paychecks per year - \$807.13 per paycheck)
75%	\$1,022.40 per month over District-paid Cap (11 paychecks per year - \$1,115.35 per paycheck)
Kaiser Low - \$1,371.00 monthly premium / \$1,130.13 District-paid Cap for full-time employees & qualifying family members	
100%	\$240.87 per month over District-paid Cap (11 paychecks per year - \$262.77 per paycheck)
75%	\$523.40 per month over District-paid Cap (11 paychecks per year - \$570.98 per paycheck)
Blue Shield 90% PPO - \$1,969.00 monthly premium / \$1,130.13 District-paid Cap for full-time employees & qualifying family members	
100%	\$838.87 per month over District-paid Cap (11 paychecks per year - \$915.13 per paycheck)
75%	\$1,121.40 per month over District-paid Cap (11 paychecks per year - \$1,223.35 per paycheck)
Blue Shield 80% PPO - \$1,744.00 monthly premium / \$1,130.13 District-paid Cap for full-time employees & qualifying family members	
100%	\$613.87 per month over District-paid Cap (11 paychecks per year - \$669.68 per paycheck)
75%	\$896.40 per month over District-paid Cap (11 paychecks per year - \$977.89 per paycheck)
Blue Shield HD PPO - \$1,323.00 monthly premium / \$1,130.13 District-paid Cap for full-time employees & qualifying family members	
100%	\$192.87 per month over District-paid Cap (11 paychecks per year - \$210.40 per paycheck)
75%	\$475.40 per month over District-paid Cap (11 paychecks per year - \$518.62 per paycheck)
Blue Shield Anchor Bronze (Minimum Value Plan) – Employee: \$728.00 / Employee + Child(ren) \$1,160.00 (Not Eligible: Spouses / Domestic Partners)	
Employee Only	
100%, 75%	\$0 per month over District-paid Cap
Employee + Child(ren) (Spouses / Domestic Partners - Not Eligible)	
100%	\$29.87 per month over District-paid Cap (11 paychecks per year - \$32.59 per paycheck)
75%	\$312.40 per month over District-paid Cap (11 paychecks per year - \$340.80 per paycheck)
Delta Dental - \$111.00 monthly premium / \$144.50 District-paid Cap for full-time employee	
100%	\$0 per month
75%	\$2.63 per month (11 paychecks per year - \$2.86 per paycheck)
50%	\$38.75 per month (11 paychecks per year - \$42.27 per paycheck)
25%	\$74.88 per month (11 paychecks per year - \$81.68 per paycheck)
Vision Service Plan - \$29.00 monthly premium <i>*May be joined with Blue Shield and Kaiser Low plans. (Kaiser High and Mid include Kaiser vision)</i>	
100%	\$0 per month
75%	\$7.25 per month (11 paychecks per year - \$7.91 per paycheck)
50%	\$14.50 per month (11 paychecks per year - \$15.82 per paycheck)
25%	\$21.75 per month (11 paychecks per year - \$23.73 per paycheck)
MetLife Insurance - \$5.55 monthly premium	
When eligible, premium 100% paid by the district.	