Woodside School District
3195 Woodside Road Woodside, CA 94062
Office: 650.851.1571 Fax: 650.851.5577

Open Enrollment 2024-25 for Health and Welfare Benefits

August is open enrollment time for your medical, dental, and vision insurance coverage. All changes will be effective September 1, 2024. Your action is required, please review the following items carefully:

- **Open enrollment closes August 23rd, 2024, please submit all forms on or by this date.**
- **Submit *signed Employee Summary Sheet* (to be mailed to address on file) no later than August 23rd, 2024, if no changes.**
- **For cash back option, please see separate form (attached) and submit proof of Health Coverage. *Dental is District mandatory.***

Medical Insurance:
For new employees, or existing employees who have questions about insurance coverage, and options please see our Pro-Co Insurance representative, who will be available via email at **lee@proco.global** or by phone at 650.289.3830.

The following is a list of **EMPLOYEE ONLY** annual rates for each of the different plans. Dependent coverage will be calculated at an **additional** cost. The maximum District contribution was increased to $13,000 and is pro-rated by FTE. The Blue Shield Gold Full PPO rate may be recalculated if we have additional employees selecting this plan.

2024-25 Health Plans	2024-24 Employee Only Annual Premium
Blue Shield Platinum Access+ HMO $25	$ 13,958
Blue Shield Gold Full PPO 750	$ 15,348
Kaiser HMO $15 co-pay	$ 12,160
Kaiser HMO $2,000 H.S.A. (Includes $2,000 District contributions to H.S.A Bank)	$ 12,999
Delta Dental	$ 661
Vision Service Plan (VSP)	$ 103

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2024-25 "CASH-BACK" ELECTION FORM

- I acknowledge receipt from the Woodside Elementary School District ("District") regarding information of the health, dental and vision insurance plans available to me as a retiree of the district for the 2024-25 school year.
- I understand that I may participate in the district's plans but decline to enroll myself in the District's Blue Shield, or Kaiser, health plans offered during the 2024-25 school year.
- The reason for declining medical coverage for myself is that I am covered under another health benefit plan.
- I further acknowledge that, if I involuntarily lose coverage under the other health benefit plan, I must request enrollment for myself in the district's health benefit plan within 30 days of receipt of notice of loss of coverage.
- I understand I may not enroll myself and/or my dependents in the district's health plan until the district's next open enrollment period unless there is a qualifying event.
- **Attached is a copy of my health insurance card,** as evidence of health care coverage under another health benefit plan. In lieu of participating in the district's health plans for retirees, I elect to participate in the district's paid "cash-back" program in which I am entitled to receive an amount equal to 50% of the district's maximum annual contribution towards the cost of health, dental, and vision plan premiums, which is $13,000 for the 2024-25 school year for 1.0 FTE.

Employee Name (please print) **Employee Signature** **Employee Signature**