

OPEN ENROLLMENT NOTICE FOR HEALTH & DENTAL INSURANCE

Each year during the month of May, you have the opportunity to make changes to your health and dental insurance coverage.

The changes are effective July 1, 2009.

IF YOU WISH TO MAKE ANY CHANGES, PLEASE COMPLETE THE FOLLOWING "REQUEST TO CHANGE HEALTH INSURANCE" FORM.
RETURN IT TO MARSHA SHINGLEDECKER @ THE BOARD OFFICE BY 5/31/09
If there are no changes, the form is not necessary.

HEALTH INSURANCE rates for 7/1/2009 – 6/30/2010

		Monthly
Plan A (\$250 PPO)		
See description summary for details	Single Rate	\$532.57
	2-Person Rate	\$1015.60
	Family Rate	\$1619.00
Plan B (\$500 PPO)		
See description summary for details	Single Rate	\$508.69
	2-Person Rate	\$970.07
	Family Rate	\$1546.42
Plan C (\$1150 HSA)		
See description summary for details	Single Rate	\$463.00
	2-Person Rate	\$882.94
	Family Rate	\$1407.54

Plan A & Plan B include prescription drug coverage. There is a \$10 co-pay for generic drugs and a \$20 co-pay for name brands for up to a one-month supply. This co-pay will apply to each prescription filled.

Plan C does not cover prescription drugs until the deductible has been met.

For each eligible employee, the District will pay the full cost of single coverage for Plan A (\$532.57). If you choose a less expensive plan, you can apply the remaining benefit dollars toward dependent coverage or a 403b tax sheltered annuity.

For those who purchase 2-person or family health coverage, the District will pay an additional \$200 per month towards the cost.

DENTAL INSURANCE rates are:

	Monthly
Single Coverage	\$23.23
Family Coverage	Additional \$48.04

IF YOU WOULD LIKE TO TAKE ADVANTAGE OF THE **OPEN ENROLLMENT PERIOD** AND SIGN UP FOR DEPENDENT COVERAGE PREVIOUSLY WAIVED, PLEASE CONTACT MARSHA OR SCOTT AT THE BOARD OFFICE TO COMPLETE THE NECESSARY ENROLLMENT FORMS BY MAY 31, 2009.

If there are no changes, this form is not necessary.

REQUEST TO CHANGE HEALTH INSURANCE

**PLEASE RETURN THIS FORM TO MARSHA SHINGLEDECKER
AT THE BOARD OFFICE BY 5/31/09**

NAME: _____

CURRENT ADDRESS: _____

I WISH TO CHANGE FROM MY CURRENT HEALTH INSURANCE PLAN TO:
(CHECK ONE)

PLAN A (\$250 PPO) _____

PLAN B (\$500 PPO) _____

PLAN C (\$1,150 HSA) _____

IF YOU CHOOSE PLAN B OR C, PLEASE TELL US WHERE YOU WANT YOUR
ADDITIONAL BENEFIT DOLLARS TO BE APPLIED.
(CHECK ONE BELOW)

DEPENDENT INSURANCE _____

403B ANNUITY _____ NAME OF COMPANY? _____

**I UNDERSTAND THAT THIS CHANGE WILL TAKE EFFECT ON JULY 1,
2009 AND THAT THE NEXT OPPORTUNITY TO CHANGE PLANS WILL BE
DURING THE 2010 OPEN ENROLLMENT PERIOD.**

SIGNATURE: _____

DATE: _____