

## Miami County ESC Insurance Options Benefits beginning January 1, 2019

Full time (FT) employees are entitled to the following insurance options. If you are not a FT employee, but work in a position that is considered as greater 30 hours per week employment, you may receive insurance benefits.

### MEDICAL – United Health Care HSA (Rates are effective 1/1/2019 thru 12/31/2019)

	Total			
	Monthly Premium	Board Cost	Employee Cost	Enrolling In:
Medical Single	\$ 664.80	\$ 531.84	\$ 132.96	Single _____
Medical Employee+Child(ren)	\$ 1,227.10	\$ 858.97	\$ 368.13	E+Child _____
Medical Family	\$ 1,704.28	\$1,193.00	\$ 511.28	Family _____
				Waive _____

**Description of Benefits (Brief)** Services must be received from participating providers (in-network)  
 No Co-pays Prescription Drug: No co-pay  
 Deductibles Single Plan \$2,000  
 Employee + Kids Plan \$4,000  
 Family Plan \$ 4,000

### DENTAL –Delta Dental (Rates are effective 1/1/2019 thru 12/31/2019)

	Monthly Premium	Board Cost	Employee Cost	Enrolling In:
Dental Single	\$ 28.26	\$ 25.43	\$ 2.83	Single _____
Dental Family	\$ 71.52	\$ 64.37	\$ 7.15	Family _____
				Waive _____

**Description of Benefits (Brief)** Annual deductible \$25.00 Single; \$50.00 family  
 Orthodontic allowance \$750.00 (lifetime)  
 Class I, II, & III annual maximum allowance \$750.00

### VISION – VSP (Rates are effective 1/1/2019 thru 12/31/2019)

	Monthly Premium	Board Cost	Employee Cost	Enrolling In:
Vision Single	\$ 7.46	\$ 6.71	\$ .75	Single _____
Vision Family	\$ 17.40	\$ 15.66	\$ 1.74	Family _____
				Waive _____

**Description of Benefits (Brief)** Examination co-pay \$10.00  
 Lenses \$25.00 every 12 months; Frames \$25.00 every 24 months  
 If lenses and frames are purchased at same time then only one co-pay applies

### LIFE - Sun Life Insurance Company Premium is paid 100% by the ESC Board Enrolling: Y N Life Insurance (Term): Policy amounts are based upon employment status. Employee cost is \$ .00

		Amount of the Policy
Class 1	Superintendent and Treasurer	Per Contract
Class 2	Mid-Level Administrators	1 X Salary
Class 3	Full Time Staff	\$50,000
Class 4	Part- Time Staff	\$25,000
Class 5	Administrative Part-Time	\$10,000

To **ENROLL IN OR DECLINE/WAIVE** Health, Dental, Vision and Life Insurance you must sign into **Benelogic On-Line Enrollment System** (Instructions attached). If the Benelogic Enrollment is not completed within 31 days of employment, you will not be eligible for insurance benefits until the open enrollment period for coverage to begin January 1<sup>st</sup> of next year.

Signature \_\_\_\_\_

Today's date \_\_\_\_\_

## Miami County ESC

### INSURANCE ON-LINE ENROLLMENT USING BENELOGIC

To ENROLL IN **OR** DECLINE/WAIVE Health, Dental and/or Vision Insurance as an employee of Miami County Educational Service Center you will need to use the online benefits system, Benelogic.

The easiest way to get to Benelogic is from the ESC webpage - [www.miami.k12.oh.us](http://www.miami.k12.oh.us). Scroll to the bottom and click on STAFF LOGIN. Now click on the RED BOX that says Sign In with Google. You may be automatically directed to the Staff Intranet site if you are already signed into your ESC email account. If so skip to Step #2. Otherwise, you will need to do Step #1 below to log in, then continue thru to complete enrollment/waive.

STEP #1 LOG in to Staff Intranet: User name is [firstname.lastname@mcapps.org](mailto:firstname.lastname@mcapps.org).

(Example: [robin.ingle@mcapps.org](mailto:robin.ingle@mcapps.org))

Password should be first name with capitalized first letter and last four digits of your social security number.

(EXAMPLE: Robin3333)

STEP #2 Click on Staff Links (on the left hand side of screen). Then (in the center of the screen) under Insurance Links click on Benelogic – (EPC Online Benefits Enrollment).

STEP #3 LOG IN TO BENELOGIC:

Your Benelogic user ID is first initial, last name, last four digits of your social security number. **This is all lower case.** (Example : ringle3333 for Robin Ingle)

Your password is the last four digits of your social security number.

Click on the green ENROLL.

Verify your personal information (social security number, birthdate and address).

Add dependents if necessary. You must enter their social security number and birthdate.

Enroll or waive coverage for each Health, Dental and Vision insurances. Be sure to put a checkmark in the box beside the name of those covered under each plan. If individual coverage you must still put a check mark beside your name under each insurance. Once all dependents are added and coverage selected, scroll down then click NEXT. Review data, scroll down and click the SUBMIT button; your screen will turn gray and a pop-up screen will appear advising you that by clicking submit the system is accepting this as your electronic signature for your benefits. Click SUBMIT to confirm. This saves your data and uploads to the insurance companies. The screen will then give you a FINISHED message. You can log out.

#### Dependent Enrollment Procedures

In order to enroll any dependents for coverage under your district's insurance plan, you must provide documents showing that they qualify for dependent status AND COMPLETE a Dependent Insurance Enrollment Affidavit (attached).

The following outlines who qualifies as a dependent and what documents are required:

**Spouse: Who qualifies:** Your legally married spouse not legally separated or divorced.

**Documents required:**

- 1) A copy of your marriage certificate showing you were married
- 2) A copy of the first page of your most recent federal tax form (1040) showing that you are still married. Please black out social security numbers and financial information to protect your financial privacy.

**Children: Who qualifies:** You or your spouse's natural child or adopted child to age 26  
A child for whom you are the legal guardian to age 18

**Documents required:**

- A copy of a birth certificate naming you / your spouse as the parent **OR**
- A copy of adoption papers naming you / your spouse as adoptee parents **OR**
- A copy of legal guardianship papers naming you as legal guardian

The Dependent Insurance Enrollment Affidavit along with appropriate documentation **MUST BE SUBMITTED DURING THE ELIGIBILITY PERIOD** before coverage will be effective. **If all documents are not provided within the eligibility period or during the open enrollment period, your dependents will not be covered this year. You will have to wait until the open enrollment period for coverage to begin January 1<sup>st</sup> next year.**

**Where to submit this form & document copies:** Human Resources

# Dependent Insurance Enrollment Affidavit

## PART I - EMPLOYEE SECTION

Employee Name: \_\_\_\_\_

Employer District: **MIAMI COUNTY EDUCATIONAL SERVICE CENTER**

By my signature on this form, I certify and warrant to my employer that all information submitted is true, correct and current as of the date signed and any attempt to enroll for /or maintain coverage for an ineligible dependent will be subject to appropriate disciplinary action. I have provided the documentation for each eligible dependent as required. I understand I will be responsible for any claim payments made for ineligible dependents.

Signature of Employee (REQUIRED): \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach this form to copies of the following documents:**

### For the Spouse:

- Copy of the marriage certificate and
- Copy of the front page of the most recent federally filed tax return confirming the spouse as a dependent.

### For Each Child:

- Copy of each child's birth certificate naming the employee/spouse as the child's Parent **OR**
- Copy of adoption papers naming the employee/spouse as the child's adoptive parent **OR**
- Copy of the appropriate court documents naming the employee/spouse as the child's legal guardian.

## Part II – Completion by Treasurer's Office

Dependent Name	SPOUSE		CHILDREN			Legal Guardianship	Employed Fulltime? Y/N	Medical	Dental	Vision
	Marriage Cert.	Recent Tax Form	Birth Cert.	Adopt						

I have certified that all of the above has been reviewed and the dependents are eligible under the group benefit plan.

District Signature: \_\_\_\_\_ Date: \_\_\_\_\_