MIAMI COUNTY EDUCATIONAL SERVICE CENTER
2000 West Stanfield Road | Troy, OH 45373-2987 | PH: (937) 339-5100 | F: (937) 339-3256
Superintendent, David Larson | *Treasurer*, Cindy A. Hale

Miami County ESC Insurance Options
Benefits beginning January 1, 2023

Full time (FT) employees are entitled to the following insurance options. If you are not a FT employee, but are employed in a position that is 30 hours or more per week, you are entitled to receive insurance benefits.

MEDICAL – United Health Care *(Rates are effective 1/1/2023 thru 12/31/2023)*
Please choose from one of the plans below:

High Deductible Health Plan (HDHP) with HSA

	Monthly Premium	Board Cost	**Employee Cost**
Employee Only	$1,080.58	$ 864.46	**$216.12**
Employee+Child(ren)	$1,994.53	$1,396.17	**$598.36**
Family	$2,770.16	$1,939.12	**$831.04**

Brief Description of Benefits – Please see the detailed benefit summaries for more information:

Deductibles: Employee Only Plan - $2,000.00
Employee+Child(ren) - $4,000.00
Family - $4,000.00
Wellness at Participating Provider – covered in full

PCP sick visit – Deductible then 0%
Specialist visit – Deductible then 0%
Prescriptions – Deductible then $0

If your spouse is eligible for medical insurance coverage through their employer, they are not eligible to enroll in the Miami County ESC medical insurance plan.

PPO Plan

	Monthly Premium	Board Cost	**Employee Cost**
Employee Only	$1,080.58	$ 935.36	**$145.22**
Employee+Child(ren)	$1,994.53	$1,559.72	**$434.81**
Family	$2,770.16	$2,166.27	**$603.89**

Brief Description of Benefits – Please see the detailed benefit summaries for more information:

Deductibles: Employee Only Plan - $2,000.00
Employee+Child(ren) - $4,000.00
Family - $4,000.00
Wellness at Participating Provider – covered in full

PCP sick visit – $20.00 co-pay
Specialist visit – $30.00 co-pay
Prescription Tier Plan - $10 / $30 / $50 / 30%

If your spouse is eligible for medical insurance coverage through their employer, they are not eligible to enroll in the Miami County ESC medical insurance plan.

Enrolling in (Please select one):

Employee Only ___ HSA ____ PPO **Employee+Child(ren)** ___ HSA ____ PPO **Family** ___ HSA ____ PPO **Waive** ____

DENTAL –Delta Dental *(Rates are effective 1/1/2023 thru 12/31/2023)*

	Monthly Premium	Board Cost	**Employee Cost**
Employee Only	$29.86	$26.88	**$2.98**
Family	$75.54	$67.99	**$7.55**

Brief Description of Benefits – Please see the detailed benefit summaries for more information:

Annual deductible $25.00 Single; $50.00 family — Orthodontic allowance $750.00 (lifetime)
Preventive services – covered in full — Annual maximum benefit $750.00/person
Basic services – 20% coinsurance after deductible; Major services – 50% coinsurance after deductible

Enrolling in: **Employee Only** ____ **Family** ____ **Waive** ____

VISION – VSP *(Rates are effective 1/1/2023 thru 12/31/2023)*

	Monthly Premium	Board Cost	**Employee Cost**
Vision Single	$ 7.77	$ 6.99	**$ .78**
Vision Family	$18.09	$16.28	**$1.81**

Brief Description of Benefits – Please see the detailed benefit summaries for more information:

Examination co-pay - $10.00 Lenses - $25.00 every 12 months Frames - $25.00 every 24 months

Enrolling in: **Employee Only** ____ **Family** ____ **Waive** ____

LIFE - Securian Financial **Premium is paid 100% by the ESC Board**

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 OR DECLINE/WAIVE** medical, dental, vision, and life insurance, you must sign into the **Benelogic On-Line Enrollment System**. If the Benelogic enrollment is not completed within 30 days of employment, you will not be eligible for insurance benefits until the open enrollment period for coverage to begin January 1st of next year.

Signature of Employee **(REQUIRED):** _____ Date: _____

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Dependent Insurance Enrollment Affidavit

TO BE COMPLETED BY EMPLOYEE:

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 copies of the following documents to this form:

For the Spouse:

- Copy of marriage certificate **and**
- Copy of the front page of recent 1040 tax return (black out financial data)

For Each Child:

- Copy of each child's birth certificate and adoption decree naming the employee/spouse as the child's parent or legal guardian

OR

- Copy of the appropriate court documents naming the employee/spouse as the child's legal guardian (if applicable)

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