# 2017-18

# 4J 2017-18 Benefit Essentials Guide

Windows User

Eugene School District 4J / FSHR

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# 4J Benefit Program Enrollment

**ALL Benefits-Eligible Employees MUST make an election within 14 days of their start date**
**Failure to meet the deadline will result in loss of health insurance coverage**

The Human Resources Department and Joint Benefits Committee are pleased to provide you this enrollment information, which summarizes the 4J Benefit Program for the 2017-2018 Plan Year. The information is not intended to fully describe the benefits of each Plan. In the case of a conflict between this information and the official plan documents, insurance policies, or the OEBB Oregon Administrative Rules the official governing documents will prevail.

## Medical/Vision Plans

### ➢ Choosing Your Plan:

All medical plans are bundled with VSP Choice Plus Plan; vision is not optional if you choose to enroll in a medical plan.
All benefit eligible employees may select one of the following three medical plans:

| **Medical Plan** | **Deductible** Individual/Family | **Out of Pocket Max** Individual/Family |
|---|---|---|
| **Birch** | $800/$2,400 | $4,000/$12,000 |
| **Cedar** | $1,200/$3,600 | $5,000/$13,700 |
| **Dogwood** | $1,600/$4,800 | $6,850/$13,700 |

| **Vision Plan** | **Plan Year Maximum** |
|---|---|
| **VSP Choice Plus** | No plan max; co-pay model |

If you cover qualified dependents and/or spouse/domestic partner, you ALL must enroll in the same Medical and Vision Plan. You must also elect the same Coverage Tier Category for both the Medical and Vision plan, i.e. employee only, employee plus spouse/domestic partner, employee plus children, employee plus family.

*For complete information of coverage, see the specific plan handbooks at:*
*https://www.modahealth.com/oebb/members/handbooks.shtml*

**Note**: All benefit eligible employees are allowed to waive medical/vision coverage during initial enrollment. However, you must be enrolled in medical/vision in order to participate in one of the dental plans.

### ➢ Choosing Your Provider Network:

Within the above Medical/Vision Plans Birch, Cedar, and Dogwood you have the option of selecting a Moda Provider Network:

**PPO - Connexus Network:** Formerly called the Statewide Plan, this plan uses the Connexus Network of providers

which includes a large number of provider options across all of Oregon. The Connexus Networks is one of the largest Preferred Provider Organizations (PPO) in Oregon.

**CCM - Synergy Network:** This plan is a Coordinated Care Model (CCM) and provides the same benefits as the Connexus Plan, but with lower premium costs in exchange for a more limited network of providers.

- If you enroll in this plan, you will need to select a participating medical home from within the network to coordinate your care. You can choose a different medical home for each person on your plan, but each covered individual must receive their care from one of the providers from within the Synergy Network to qualify for in-network benefits. To choose a medical home you will need to create a MyModa account using your new insurance ID number. Create your MyModa account at www.modahealth.com/mymoda/logon.do

You always have the option of using out-of-network providers for both Connexus and Synergy plans, but note that your benefit will be subject to all out-of-network conditions.

# Dental Plans

You ***must*** be enrolled in a Medical/Vision plan in order to select a Dental plan.

If you cover qualified dependents and/or spouse/domestic partner, you ALL must enroll in the same Dental Plan. You must also elect the same Coverage Tier Category for Medical, Vision, and Dental plans, i.e. employee only, employee plus spouse/domestic partner, employee plus children, employee plus family.

All benefit eligible employees may select from following Dental Plans, or choose to waive dental coverage:

- **Delta Dental Premier Plan 5 • Includes Orthodontia • Incentivized Plan**
  - Under this incentive plan, benefits start at 70 percent for your first plan year of coverage. Thereafter, benefit payments increase by 10 percent each plan year (up to a maximum benefit of 100 percent) provided the individual has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10 percent reduction in benefit payment the following plan year, although payment will never fall below 70 percent.
  - You may choose your dentist from the Delta Dental Premier network. Network dentists have agreed to provide services at contracted rates. There are no annual deductibles for Preventive and Diagnostic Services.
  - Non-Delta Dental Premier dentists are not required to provide services at contracted rates. The plan pays out-of-network providers based on the maximum plan allowance. You may be required to file your claim and you may be charged for amounts that exceed the maximum plan allowance.
  - You can access the Moda Health website at: https://www.modahealth.com/ProviderSearch/faces/webpages/search.xhtml to search for a Delta Dental Premier Dentist under “Find a doctor, dentist, pharmacy or clinic”.

- **Delta Dental Premier Plan 6 • NO Orthodontia • Non-incentivized Plan**
  - You may choose your dentist from the Delta Dental Premier network. Network dentists have agreed to provide services at contracted rates. There are no annual deductibles for Preventive and Diagnostic Services.
  - Non-Delta Dental Premier dentists are not required to provide services at contracted rates. The plan pays out-of-network providers based on the maximum plan allowance. You may be required to file your claim and you may be charged for amounts that exceed the maximum plan allowance.
  - You can access the Moda Health website at: https://www.modahealth.com/ProviderSearch/faces/webpages/search.xhtml to search for a Delta Dental Premier Dentist under “Find a doctor, dentist, pharmacy or clinic”.

- **Willamette Dental Group Plan 8**
  - The Willamette Dental Group plan provides set co-payments so that you always know what your out-of-pocket costs will be. There are no annual deductibles and no maximums for covered benefits.
  - If you receive services from a non-Willamette Dental Group provider you will be responsible for all costs. If you are currently covered by a different carrier and switch to Willamette Dental Group, you will most likely need to change dental providers.
  - You can access the OEBB Willamette Dental Group website at: https://www.willamettedental.com/oebb to find an In-Network dentist.

**Note**: All benefit eligible employees are allowed to waive dental coverage during initial enrollment. However, dental benefits are subject to 12-month waiting period restrictions for members who previously waived dental coverage for themselves and/or a dependent and enroll in the future. The “waiting period” restrictions only allow an exam and cleaning, with no other preventive/diagnostic, basic, major or orthodontia benefits for the first 12 months of coverage.

# Optional Benefits

## Optional Term Life Insurance

You may purchase Optional Term Life Insurance for you and your family. The amount of coverage you need is a personal decision. **An employee must be enrolled in optional life coverage at or higher than the level requested for the spouse/domestic partner or dependents.**

- To review or change coverage go to *"MyOEBB"* at https://myoebb.org/oebb/!pb.main
- You must indicate smoking status for yourself and spouse/domestic partner (regardless of enrollment).
  - This information will be used to determine premium amount for Optional Term Life Insurance during the 2017-2018 plan year.
  - OEBB applies a Tobacco Rate for employee and/or spouse/domestic partner enrolled in any Optional Term Life insurance who has used tobacco in the past 12 months.

  **Non-Tobacco Rated Criteria:**
  - If employee HAS NEVER used tobacco or HAS NOT used tobacco in the past 12 months.
  - If spouse/domestic partner HAS NEVER used tobacco or HAS NOT used tobacco in the past 12 months.

  **Tobacco Rated Criteria:**
  - If employee HAS used tobacco in the past 12 months.
  - If spouse/domestic partner HAS used tobacco in the past 12 months.
- Evidence of Insurability/Proof of Good Health will be required if:
  - An employee wants to newly enroll in Optional Life Insurance for themselves or their spouse/domestic partner.
  - A currently enrolled employee/spouse/domestic partner elects to increase life coverage beyond the Guarantee Issue Amount.
  - A currently participating employee enrolled in less than $100,000 of coverage, may increase their coverage during open enrollment by $20,000 not to exceed $100,000 as guaranteed issue. Otherwise, proof of good health will be required.
  - A currently participating spouse/domestic partner enrolled in less than $30,000 of coverage may increase their coverage during open enrollment by $20,000 not to exceed $30,000 as guaranteed issue. Otherwise, proof of good health will be required.
- To provide **Evidence of Insurability** complete the "Standard Medical History Statement", which can be obtained from The Standard Insurance company website at: http://www.standard.com/mybenefits/oebb/

## Flexible Spending Accounts (FSA)

A Flexible Spending Account allows employees to save money by paying for qualifying health related and/or dependent care expenses with pre-tax dollars. You decide how much to set aside to pay for eligible expenses incurred during the plan year. You make a separate election for each account. Your election will remain in place through September 30, 2018.

- Participation requires a new enrollment each year.
- The amount is deducted on a pre-tax basis from your paycheck in equal amounts throughout the year before social security, federal and in most cases state and local income taxes are deducted.
- Any health care or dependent care expenses that are paid from the Flexible Spending Account may not be claimed as a deduction or credit when filing your income tax return.
- Money set aside for dependent care expenses cannot be used to reimburse health care expenses and vice-versa.

## ➢ Health Care FSA

- Plan Year and Calendar Year Maximum allowed is $2,600.
- Mid-Year elections changes **are <u>not</u> allowed** for the Health FSA plan.
- Use the FSA for eligible health related expenses for you, your spouse and any dependent you list on your tax return, provided they have not been reimbursed by other coverage. Examples include: health plan deductibles, prescriptions and other copayments or coinsurance.
- Domestic Partner and their family member health related expenses are not eligible for reimbursement.
- You can **roll over up to $500** into the following plan year of your current year Health FSA remaining balances.
- **Use-it-or-Lose-it Rule** applies to unused balances above $500.
- **Benny Debit MasterCard** can be issued to make transactions easier! PacificSource may still request a copy and/or the Explanation of Benefits to verify eligible expenses.

## ➢ Dependent Care FSA

- Plan Year and Calendar Year Maximum allowed is $5,000 ($2,500 if married and filing separately).
- The amount you contribute to your account cannot be greater than your income or your spouse's income—whichever is less.
- You will be reimbursed for dependent care expenses only up to the amount of your Dependent Care Spending Account balance.
- Domestic Partner's children's day care expenses are **not** eligible for reimbursement.
- Mid-Year elections changes are only allowed with a Qualifying Life Event status change and must be made within 31 days of the life event.
- **Use-it-or-Lose-it Rule** applies. IRS rules require that any money left in your Dependent Care FSA at the end of the Plan Year must be forfeited. Contribution amounts **are not carried forward** from one year to the next year.
- Eligible Dependent Care expenses are for child day care or other dependent day care services when:
    - you and your spouse work outside the home (this is also true if your spouse is actively looking for work).
    - you work outside the home and your spouse is a full-time student at least five months of a year.
    - you work outside the home and your spouse is incapable of self-care.
    - your child(ren) is under age 13, as well as your spouse or an IRS Section 125 qualified child or relative—who is physically or mentally incapable of self-care.
- **Note**: You cannot use reimbursed expenses on the Earned Income Credit, which may be more advantageous if your family income is below $25,000.

# Additional 4J Benefits

Benefit programs are one of the many ways Eugene School District 4J takes care of its eligible staff and their dependents. 4J automatically provides several benefits for eligible employees and pays the full cost for basic life insurance, AD&D insurance and long term disability coverage. All benefit eligible employees are also offered a variety of other benefits such as no-cost services at our on-site Wellness Clinic, an Employee Assistance Plan and no-cost Wellness Events throughout the school year. The following are highlights of these employer-provided benefits:

## Basic Life and AD&D Insurance

Basic Life and Accidental Death & Dismemberment (AD&D) coverage, both in the amount of $50,000, are provided for all benefit eligible employees, and are paid by Eugene School District 4J. For more information on these benefits, see The Standard's Insurance Brochure at: http://www.standard.com/eforms/14729_646595.pdf

## Long Term Disability Insurance

The Long Term Disability (LTD) Plan provides a source of income should you experience a qualifying long-term illness or injury that prevents you from working. 4J provides this benefit to eligible employees at no cost to the employee. For more information visit: http://www.4j.lane.edu/hr/benefits/life-and-other-insurance/long-term-disability/

## 4J Wellness Clinic

The 4J Wellness Clinic is a medical clinic providing individualized, comprehensive care and follow up. The clinic is run through a joint effort of Cascade Health and the Joint Benefits Committee. The clinic provides benefit eligible 4J employees and their families, as well as enrolled retirees and their insurance-covered dependents with pre-paid routine medical care at no cost to the patient. For more information visit: http://www.4j.lane.edu/hr/benefits/wellness-clinic/

- The clinic is located at 200 N. Monroe Street in the 4J District Office and is open for appointments and scheduling Monday through Friday, from 9 a.m. to 6 p.m.
- Call the clinic at 541-686-1427 to make an appointment.

## Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) provides services to help employees and their family members privately resolve problems that may interfere with work, family, and other important areas of life. EAP services include counseling, legal services, financial services and other work-life balance services. For more information visit: https://www.myrbh.com/

- Call 1-866-750-1327 or visit https://www.myrbh.com/ with the access code: OEBB.
- Services are always confidential with no private information reported to the District.
- For you and your household members EAP services includes:
    - 5 no cost counseling sessions per issue per year.
    - Life Balance services i.e. legal services, financial services, eldercare referral, will preparation, identity theft services, childcare referral services.
    - Wellness services i.e. health coaching and online wellness portal

# Glossary of Insurance Terms

This is a list of common insurance terms used throughout your benefits materials. A complete glossary of health coverage and medical terms can be found by clicking **here**.

**Balance Billing:** When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

**Co-insurance:** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if Moda's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. Moda pays the rest of the allowed amount.

**Deductible:** The amount you owe for health care services that Moda covers before Moda begins to pay. For example, if your deductible is $1200, your plan won't pay anything until you've met your $1200 deductible for covered health care services subject to the deductible. ***The deductible does not apply to all services***.

**Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Out-of-Pocket Limit:** The most you pay during the benefit year before your health plan begins to pay 100% of the allowed amount. This limit does not include your monthly premium, balance-billed charges, or non-covered services.