Elko County School District

850 Elm Street Elko, NV 89801 Phone 775-738-5196

Open Enrollment
Plan year 2019

The Elko County School District offers teachers, staff and administrators two medical pan options, a Health Savings Account (HSA) qualifed plan and a Co-Pay plan. A comparison of the benefits for the HSA plan and the Co-Pay plan are shown below. The employee only premium for the both the HSA Plan and the Co-Pay plan will be paid by the District. Employees are responsible for any dependent premiums. Dependent premiums for the HSA plan are $50 per month lower than for the Co-Pay plan. The District also sponsors a Health Savings Account program and will make a matching contribution of $50 per month for each employee enrolling in the plan.

Plan Compairson

Benefits	Current Co-Pay Plan	HDHP
Medical Deductible	$600 individual / $1,300 Family	$2,500 individual / $5,000 Family
Dental Deductible	$50 / $150	Included
Coinsurance	80/20%	80/20%
Out-of-Pocket Maximum	$3,650 per participant	$3,500 individiual / $6,000 family
Doctor's Office Co-Pay	$35 Co-Pay	Deductible then Coinsurance
Specialist Co-Pay	$50	Deductible then Coinsurance
Emergency Room	$100	Deductible then Coinsurance
Prescriptions	After Deductible $15/$30/$45	Deductible then Coinsurance
Teledoc	$0	$45 (applies to deductible)

Employee Premiums

Employee	$0.00	$0.00
Employee Plus 1	$430	$380
Employee Plus 2	$534	$484
Employee Plus 3 or More	$640	$590

HSA Contributions

Annual Employee Contribution	$0.00	$600
Annual Matching ECSD Contribution	$0.00	$600

HSA Contribution Limits for 2019

Annual Maximum	Individual	$3,500
	Family	$7,000
	Over 55 Catch-up	$1,000

For questions, please reach out to

Leslee Zeiler, Human Resources ECSD, 775-738-5196
Trinity Steelman, LP Insurance Services, 775-299-5600
Anne McMullen, LP Insurance Services, 775-299-5602

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850 Elm Street Elko, NV 89801 Phone 775-738-5196

Open Enrollment
Plan year 2019

The Elko County School District offers retirees two medical pan options, a Health Savings Account (HSA) qualifed plan and a Co-Pay plan. A comparison of the benefits for the HSA plan and the Co-Pay plan are shown below. Retirees are responsible for the premium. However, those electing to participate in the HDHP will receive a $50 reduction in cost per month. The District will also sponsor a Health Savings Account program. Retirees may establish an HSA account if under age 65. Retirees over age 65 receiving Medicare benefits are not eligibile for an HSA account.

Plan Compairson

Benefits	Current Co-Pay Plan	HDHP
Medical Deductible	$600 individual / $1,300 Family	$2,500 individual / $5,000 Family
Dental Deductible	$50 / 150	Included
Coinsurance	80/20%	80/20%
Out-of-Pocket Maximum	$3,650 per participant	$3,500 individiual / $6,000 family
Doctor's Office Co-Pay	$35 Co-Pay	Deductible then Coinsurance
Specialist Co-Pay	$50	Deductible then Coinsurance
Emergency Room	$100	Deductible then Coinsurance
Prescriptions	After Deductible $15/30/45	Deductible then Coinsurance
Teledoc	$0	$45 (applies to deductible)

Retiree Premiums

Retiree without Medicare	$761	$727
Spouse	$430	$380
Retiree with Medicare	$268	$234
	$193	$159

HSA Contribution Limits for 2019

Annual Maximum	Individual	$3,500
	Family	$7,000
	Over 55 Catch-up	$1,000

For questions, please reach out to

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☐ Initial Enrollment ☐ Beneficiary Change ☐ Change Request
☐ COBRA Qualifying Event _____
☐ Retiree Date of Qualifying Event _____

SECTION 1: EMPLOYEE INFORMATION

Date of Full-Time Hire	Group #	Wage	Occupation/Job Title	Social Security Number
_____/_____/_____	000JJE834			

First Name	Last Name	Middle Initial	Gender	Date of Birth (mo/day/year)
			☐ Male ☐ Female	

Mailing Address	Home Phone	Cell Phone
	( ) -	( ) -

City	State	Zip Code

Email	Marital Status
	☐ Married ☐ Single ☐ Widowed ☐ Divorced

SECTION 2: BENEFIT PLAN SELECTION

		☐ Co-Pay Plan	☐ HDHP w/ HSA
Medical Dental Vision (Select One)	☐ Employee	$0.00	$0.00
	☐ Employee + 1	$430	$380
	☐ Employee + 2	$534	$484
	☐ Employee + 3 or more	$640	$590

COMPLETE THIS SECTION ONLY IF YOU DO NOT WANT DEPENDENT COVERAGE
Waive Coverage for: ☐ Spouse ☐ Child(ren)
Reason: ☐ Cost ☐ Other Coverage (Attach copy of ID card)
I understand I (we) will not be able to enroll later unless special enrollment requirements are met or at open enrollment. Pre-existing limitations may apply.
(sign here) _____

SECTION 3: HEALTH SAVINGS PLAN BENEFIT ELECTION

Those enrolling in the HDHP $2,500 will be eligible to receive up to $50 per month in matching HSA contribution. *(If you are joining the plan mid-year, your first-year contribution will be pro-rated.)*

☐ I wish to participate in the matching program and will contribute as follows: ☐ I Waive Participation in the HSA program

I authorize the following pre-tax deductions*:
$_____ Annual Election and $_____ Per Pay Period Election (12/ year)

* 2018 HSA combined contribution limits are $3,500 for an individual, $7,000 if enrolled as family. Employees over age 55 may make an additional $1,000 catch-up contribution.

SECTION 4: FAMILY INFORMATION

If you have selected coverage above that includes any dependents, you are required to complete the following information:

Add(A) Delete(D	Dependents (Last, First, MI)	Relationship	Gender	Social Security Number (IRS Requirement)	Date of Birth (Mo/Day/Yr)	Is this dependent disabled?
		Spouse	☐ Male ☐ Female			☐ Yes ☐ No
		Child	☐ Male ☐ Female			☐ Yes ☐ No
		Child	☐ Male ☐ Female			☐ Yes ☐ No
		Child	☐ Male ☐ Female			☐ Yes ☐ No
		Child	☐ Male ☐ Female			☐ Yes ☐ No

Children are eligible up to age 26. If listed spouse is a domestic partner, please provide copy of affidavit.

SECTION 4: MEDICAL COORDINATION OF BENEFITS

Have you, your spouse or any dependent children had coverage in the past 63 days? ☐ Yes ☐ No (If YES, complete the following)

Type of Coverage: ☐ Prior Employer ☐ Spouse Plan ☐ TriCare ☐ Medicare ☐ Indian Health Services ☐ Parent's Plan

Name of Insured	Insured Birthdate (Mo/Date/Yr)	Identification Number	Group Number	Group Name

Insurance Company Name	Insurance Company Address	Start & End Dates	Who does the insurance cover?
			☐ You ☐ Spouse ☐ Children

*If coverage includes children and parents are divorced, which parent has custody?
☐ Mother ☐ Father

Does Divorce decree establish medical responsibility?
☐ Yes ☐ No Parent?

Does coverage include: **Dental?** ☐ Yes ☐ No **Prescription Drugs** ☐ Yes ☐ No **Vision** ☐ Yes ☐ No	Is anyone in your family Medicare Eligible? ☐ Yes ☐ No If yes, name _____

SECTION 5: EMPLOYEE LIFE AND DISABILITY INSURANCE

The employee signing this form names the following person(s) as primary beneficiary for any Life payment upon his or her death. For any other type of beneficiary, please use a Beneficiary Designation form available from your HR/Benefits Professional. Unless designated otherwise, payments will be made in equal shares, or all to the survivor. The employee understands that he or she has the right to change this designation at any time.

Do you understand and agree that coverage will not become effective unless you are in Active Full-Time Work on the date of enrollment and the effective date of insurance? ☐ **Yes** ☐ **No**

**Your coverage will be effective the first day of the month following 90 days of active employment.*

Basic Life and AD&D	☐ **Paid in full by Employer – Twice Annual Salary**
Voluntary Life Insurance	☐ **Paid in full by Employee –If electing, please attach application**
Long-term Disability	☐ **Paid in full by Employee –If electing, please attach application**

Primary Beneficiary – Full Name Last, First, Middle Initial	% of Benefit	**Relationship**	Date of Birth **(Mo / Day / Yr)**	**Address** **Street, City, State, Zip**
Contingent Beneficiary – Full Name Last, First, Middle Initial	% of Benefit	**Relationship**	Date of Birth **(Mo / Day / Yr)**	**Address** **Street, City, State, Zip**

Under your primary beneficiary benefit, the total benefit needs to equal 100%. If the primary beneficiary/beneficiaries are deceased please note the benefits will go to your contingent beneficiary listed.

SECTION 6: AUTHORIZATION

AUTHORIZATION

PAYROLL DEDUCTION AUTHORIZATION: I authorize my employer to deduct from my earnings any premiums for the insurance I have applied for as shown above. I also authorize the required employee contributions for the healthcare premium to be made through pretax payroll deductions. I understand that contributions for all voluntary benefit programs, if elected, are on an after-tax basis.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to the application ("Us"), I authorize any health care professional or entity to give the Health Plan/Insurer, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose. A photocopy of this authorization will be as valid as the original.

NOTICE OF ENROLLMENT RIGHTS: I understand that Elko County School District pays 100% of the premium for my benefits. I may not waive benefits and my benefits through ECSD will be primary over any other coverage. I further understand that if I waive coverage for dependents, if any, and they desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as of marriage, birth, adoption, or placement or adoption. I may be able to enroll my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have received and read the enrollment packet provided to me. I understand that, under the terms of the plans, I cannot change/revoke my medical and/or dental choices during the plan year except for reasons of special enrollment.

THE INFORMATION PROVIDED ON THIS APPLICATION IS ACCURATE AND COMPLETE. I understand and agree that any omissions or incorrect statements knowingly made by us on this application constitute fraud. I understand that coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer.

Employee Signature	**Date**

ECSD
Elko County School District