INSURANCE and CAFETERIA PLAN INFORMATION 2022-2023

FULL TIME CERTIFIED AND CLASSIFIED OVER 37.5 HOURS

You MUST COMPLETE a SEPARATE enrollment/waiver form for Health, Life, Dental and Vision Insurance benefits offered below.

Details on all plans may be found at www.ecusd7.org under Departments, then Business Operations. http://ecusd7.org/departments/business-operations/ There is a waiting period for all life, health, vision and dental insurance through the district. Your insurance will start on the first of the month following your active hire date according to the Board agenda.

LIFE INSURANCE :

July 1, 2022-June 30, 2023 One America Life Insurance Company

a. The **DISTRICT WILL PAY** the premium for $20,000 Basic Group Term Life and AD&D insurance ($2.86) for active **full-time** certified, classified or exempt employee. http://ecusd7.org/departments/business-operations/#tab-id-8
(Part-time certified and classified employees may purchase if scheduled to work over 10 hours, but less that 37.5 hours per week)

b. You may, **AT THIS TIME ONLY**, purchase an additional $30,000 Voluntary ($10.50 per mo.) and AD&D or $80,000 Voluntary ($28.00 per month) and AD&D life insurance on yourself. Please indicate your choice on the enrollment form

c. You may, **AT THIS TIME ONLY**, purchase $5,000 Dependent life on your spouse (subject to age requirements) and $2,000 life on each child, (under age 19) at a total cost to you of $1.39 per month.

d. **If you decline participation in the health insurance coverage**:

- **CERTIFIED**: You may elect to have $60,000 Basic Group Term Life and AD&D insurance coverage premiums paid by the District **IN LIEU** of health insurance
- **CLASSIFIED**: You may elect to have $50,000 Basic Group Term Life and AD&D insurance coverage premiums paid by the District **IN LIEU** of health insurance for full-time employee.

HEALTH INSURANCE-District 7 offers two health insurance plans

July 1, 2022-June 30, 2023 United Health Care Point of Service **(POS)** Choice Plus Plan

This plan offers your choice of providers, but you receive the most benefits when you visit the network providers and pharmacies, etc.
Effective July 1, 2022 monthly premiums will be $750.00 for single coverage and $1,530.00 for family coverage

SINGLE COVERAGE PREMIUM PAYROLL DEDUCTION:

Classified employee scheduled 37.5 hours/week	District 7 pays benefit	$ 750.00 monthly premium
	Employee's premium deduction	$ 0.00 monthly premium
Certified employees	District 7 pays benefit	$ 750.00 monthly premium
	Employee's premium deduction	$ 0.00 monthly premium

FAMILY COVERAGE PREMIUM PAYROLL DEDUCTION:

Classified ESSPA employee scheduled 37.5 hours/week	District 7 pays benefit	$ 750.00 monthly premium
	Employee's premium deduction	$ 780.00 monthly premium
Classified EFSE employee scheduled 37.5 hours/week	District 7 pays benefit	$ 800.00 monthly premium
	Employee's premium deduction	$ 730.00 monthly premium
Certified employees	District 7 pays benefit	$ 800.00 monthly premium
	Employees premium deduction	$ 730.00 monthly premium

July 1, 2022-June 30, 2023 United HealthCare Health Savings Account (HDHP/H S A) Plan

This plan includes a Qualified High Deductible health insurance plan and the portable Health Savings Account.
Effective July 1, 2022, monthly premiums will be: $628.00 for single coverage and $1,266.00 for family coverage - $100 contribution to Health Savings Account (HSA)

SINGLE COVERAGE PREMIUM PAYROLL DEDUCTION:

Classified employee scheduled 37.5 hours/week	District 7 pays benefit	$ 628.00 monthly premium
	Employee's premium deduction	$ 0.00 monthly premium
Certified employees	District 7 pays benefit	$ 628.00 monthly premium
	Employee's premium deduction	$ 0.00 monthly premium

FAMILY COVERAGE PREMIUM PAYROLL DEDUCTION:

Classified ESSPA employee scheduled 37.5 hours/week	District 7 pays benefit	$ 628 .00 monthly premium
	Employee's premium deduction	$ 638.00 monthly premium
Classified EFSE employee scheduled 37.5 hours/week	District 7 pays benefit	$ 678.00 monthly premium
	Employee's premium deduction	$ 588.00 monthly premium
Certified employees	District 7 pays benefit	$ 678.00 monthly premium
	Employees premium deduction	$ 588.00 monthly premium

(Your premium contribution will be **PRE-TAX** for health insurance—see Stacy Ehrman in the Business Office within 30 days of eligibility date with any questions.)

DENTAL INSURANCE: 2021-2022 Delta Dental of Illinois Preferred Plan

This plan offers your choice of providers, but you receive the most benefits when you visit the network providers and pharmacies, etc. Full time Certified and/or Classified employees (scheduled to work 10 hours or more a week) may purchase dental insurance by paying the monthly premium listed below. (premium effective October 1, 2021 through September 31, 2022)

1. Single: $27.39 2. Family: $85.77

(Your premium will be **PRE-TAX** for dental insurance—see Stacy Ehrman in the Business Office within 30 days of eligibility date with any questions.) 7.1.21

VISION INSURANCE: 2022-2023 Eyemed Select Plan

This plan offers your choice of providers, but you receive the most benefits when you visit the network providers and pharmacies, etc. Full time Certified and/or Classified employees (scheduled to work 10 hours or more a week) may purchase vision insurance by paying the monthly premium listed below. (premium effective July 1, 2022 through June 30, 2023)

1. Single: $5.90 2. Family: $12.69

(Your premium will be **PRE-TAX** for vision insurance—see Stacy Ehrman in the Business Office within 30 days of eligibility date with any questions.)

HEALTH CARE REIMBURSEMENT ACCOUNT

The District offers a Flexible Spending account for Health Care Reimbursement to full time employees (sometimes referred to as a cafeteria plan). This account lets you set aside a designated amount of your paycheck into an account—before paying taxes. During the year, participants have access to this account for reimbursement of certain expenses that insurance does not cover. For more information, go to www.tri-starsystems.com You must be scheduled to work 20 hours per week and complete an enrollment form to participate.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

The District offers a Flexible Spending account for Dependent Care Reimbursement to full time employees (sometimes referred to as a cafeteria plan). This account lets you set aside a certain amount of your paycheck into an account—before paying taxes. Participants have access to this account for reimbursement of qualifying dependent care expenses incurred during the plan year. For more information, go to www.tri-starsystems.com You must be scheduled to work 20 hours per week and complete an enrollment form to participate.

IMPORTANT NOTE: YOU MUST ENROLL FOR ANY OR ALL OF THESE PLANS WITHIN 30 DAYS OF YOUR EFFECTIVE DATE. YOUR EFFECTIVE DATE FOR INSURANCE WITH A COMPLETED, RETURNED APPLICATION IS THE FIRST OF THE MONTH FOLLOWING THE DATE OF HIRE (according to the Board Agenda) or ACTIVE EMPLOYMENT.

YOU MUST INITIAL AND SIGN THE BOX BELOW AND RETURN THIS COMPLETED FORM (with enrollment/waiver forms) TO THE PERSONNEL OFFICE WITHIN 30 DAYS OF YOUR DATE OF HIRE.

Please initial below the items that apply:

_____ **I DO NOT wish to enroll in the POS HEALTH insurance plan offered by District 7.**

_____ **I DO NOT wish to enroll in the HDHP/H S A HEALTH insurance plan offered by District 7.**

_____ **I DO NOT wish to enroll in the LIFE insurance plan offered by District 7.**

_____ **I DO NOT wish to enroll in the DENTAL insurance plan offered by District 7.**

_____ **I DO NOT wish to enroll in the VISION insurance plan offered by District 7.**

_____ **I DO NOT wish to participate in the Health Care Reimbursement Plan offered by District 7.**

_____ **I DO NOT wish to participate in the Dependent Care Reimbursement Plan offered by District 7.**

_____ **I acknowledge receipt of the COBRA Rights, Marketplace Coverage and Privacy Policy forms.**

_____ **I understand all insurance benefit premium deductions are pre-taxed.**

_____ **I understand that completion of this form DOES NOT ENROLL ME in any coverage.**

_____ **I understand that if I wish to CHANGE my decision on any of these benefits, or if I have a qualifying event that would affect my benefits, I must notify Stacy Ehrman within 30 days of the qualifying event.**

Signed_____ **Date**_____

Please print name_____ **School**_____