

Perry's Copy

S | D | I | S Special Districts Insurance Services

BAKER COUNTY LIBRARY DISTRICT

Quote March 15, 2024 for rates effective July 1, 2024

The premiums shown below are based on census data submitted with your proposal request. Final rates may vary if actual enrollment differs from the original census.

Minimum Employer Contribution Requirement: 75% employee & 0% dependent OR 50% employee & 50% dependent.

Minimum Participation Requirement: 75% of eligible employees & 75% of eligible dependents.

The premiums below will require review if the effective date is after: July 1, 2024

CENSUS					
	Employee Only	Employee + Spouse	Employee + Family	Employee+ Child(ren)	Total
Subscribers	11	1	0	0	12

MEDICAL PLAN OPTIONS					
Regence Preferred Network	Employee Only	Employee + Spouse	Employee + Family	Employee+ Child(ren)	Total Monthly Premium
Blue PPO II	\$1,375.00	\$2,751.00	\$3,920.00	\$2,544.00	\$17,876.00
Blue PPO II-A	\$1,312.00	\$2,625.00	\$3,741.00	\$2,428.00	\$17,057.00
Blue PPO III	\$1,260.00	\$2,519.00	\$3,590.00	\$2,330.00	\$16,379.00
Blue PPO IV	\$1,170.00	\$2,341.00	\$3,335.00	\$2,165.00	\$15,211.00
Blue PPO V	\$1,127.00	\$2,255.00	\$3,213.00	\$2,086.00	\$14,652.00
Blue PPO VI	\$1,074.00	\$2,149.00	\$3,062.00	\$1,988.00	\$13,963.00
Blue PPO VII	\$1,041.00	\$2,083.00	\$2,968.00	\$1,927.00	\$13,534.00
Red PPO C	\$1,243.00	\$2,486.00	\$3,543.00	\$2,300.00	\$16,159.00
Red PPO D	\$1,197.00	\$2,394.00	\$3,411.00	\$2,214.00	\$15,561.00
Red PPO E	\$1,111.00	\$2,222.00	\$3,166.00	\$2,055.00	\$14,443.00
Red PPO F	\$1,061.00	\$2,122.00	\$3,025.00	\$1,963.00	\$13,793.00
Red PPO H	\$1,002.00	\$2,003.00	\$2,855.00	\$1,853.00	\$13,025.00
Red PPO J	\$972.00	\$1,944.00	\$2,770.00	\$1,798.00	\$12,636.00
Red PPO K	\$946.00	\$1,891.00	\$2,695.00	\$1,749.00	\$12,297.00
Red PPO L	\$912.00	\$1,825.00	\$2,601.00	\$1,688.00	\$11,857.00
HSA #1	\$830.00	\$1,660.00	\$2,365.00	\$1,535.00	\$10,790.00

Renewal
monthly
↑ 489/mo

x12 =
147,564
Annual
↑ 8268
= 5.9%

DENTAL PLAN OPTIONS					
Denita Dental Premier Network	Employee Only	Employee + Spouse	Employee + Family	Employee+ Child(ren)	Total Monthly Premium
OPTION 1 \$1,500 Constant Dental	\$57.00	\$103.00	\$149.00	\$108.00	\$730.00
OPTION 2 \$1,500 Incentive Dental	\$61.00	\$112.00	\$163.00	\$116.00	\$783.00
OPTION 3 \$2,000 Constant Dental	\$62.00	\$109.00	\$158.00	\$114.00	\$791.00
OPTION 4 \$2,000 Incentive Dental	\$66.00	\$121.00	\$175.00	\$125.00	\$847.00

x12 =
9492
↑ 372
= 4.1%

Willamette Dental-Ortho Included					
	Employee Only	Employee + Spouse	Employee + Family	Employee+ Child(ren)	Total Monthly Premium
OPTION 5 Standard Plan	\$51.00	\$100.00	\$153.00	\$103.00	\$661.00
OPTION 6 Enhanced Plan	\$63.00	\$124.00	\$190.00	\$128.00	\$817.00

COMBINED
157,050
↑ 8640
= 5.8%

CURRENT RATES					
Plan	Employee Only	Employee + Spouse	Employee + Family	Employee+ Child(ren)	Total Monthly Premium
Red PPO K	\$893.00	\$1,785.00	\$2,544.00	\$1,651.00	\$11,608.00
OPTION 3 \$2,000 Constant Dental	\$59.47	\$105.65	\$153.19	\$110.65	\$759.82

x12 =
139,296
x12 =
9120
148,416

Recd 3/21/24 CH



2024 SDIS Life & Disability Plans with Standard

The rates for the Life/AD&D plans as well as the STD plans are charged on a Per Employee Per Month (PEPM) basis. The LTD plans rates are charged as a percent of covered payroll.

BAKER COUNTY LIBRARY DISTRICT

Life/AD&D Plans

	Option 1	Option 2	Option 3	Option 4	Option 5
Life/AD&D Schedule	\$10,000	\$20,000	\$50,000	1 X Annual Salary	\$100,000
Rates- PEPM	\$3.00	\$6.00	\$13.00	\$14.00	\$30.00
Dependent Life	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Rates-PEPM	\$2.00	\$2.00	\$2.00	\$2.00	\$2.00

Short-Term Disability Plans

	Option 5	Option 6
STD Plan	60% to \$900 per week	60% to \$900 per week
Duration	Up to 90 days	Up to 180 days
Rates-PEPM	\$8.00	\$11.00

Long-Term Disability Plans

	Option 1	Option 2
LTD	60% to \$10,000	60% to \$10,000
Elimination Period	90 Days	180 Days
Benefit Duration	SSNRA	SSNRA
Rates - % of CP	\$0.551% of covered payroll	\$0.436% of covered payroll

<--- 2024 LTD PEPM PREMIUM

Note: A current census is required to confirm the monthly premium for a LTD proposal.

INDICATES CURRENT PLAN

Dear Valued District Member,

Enclosed please find your 2024 Special Districts Insurance annual renewal.

Our health plan renewal is packed with good news and valuable information! Please take the time to review this memo in its entirety and share it with your district employees.

PRICING

- **MEDICAL/RX RENEWAL ACTION IS 7% FOR THE 2024 PLAN YEAR.** We believe this is competitive considering the inflation pressure that every health plan is facing. (Keep in mind our plans are demographically rated, so the actual renewal increase to your plan may be higher or lower, depending on your plan enrollment. (** OFCA rates and plans differ)
LIFE & LTD PLANS WITH STANDARD All basic life rates will increase by 10% and LTD rates will increase by 5%. The rates are guaranteed for two years.

PLAN UPDATES/ENHANCEMENTS

- **MEDICALLY NECESSARY BARIATRIC SURGERY** (subject to the medical policy for Regence) will be a covered benefit under the health plan with the 7/1/2024 renewal.
- **VISION COVERAGE WILL MOVE TO VSP** Providers have been confused by the current design of the vision plan, so SDIS has made this change to reduce confusion and make it easier for our members to use vision benefits. If a member is unable to locate an in-network VSP provider within 10 miles (urban/suburban) or 25 miles (rural), VSP will allow in-network benefits from an out-of-network provider. In addition, the vision allowance may be used for multiple purchases until it is exhausted. **NOTE: This change requires new ID cards.**
- **NEW EMPLOYER PAID LIFE OPTION** SDIS is offering a flat \$100,000 life option at renewal. Complete the master application to confirm which life option your district will select in 2024.
- **STD PLAN OPTIONS 1-4 WILL NOT BE OFFERED AT RENEWAL** due to the implementation of Paid Leave Oregon. If your district is enrolled in one of these plans currently, your renewal packet will reflect a move to either plan 5 or 6. Below is a chart indicating this change. Each district will accept/decline this election during the Master Application process.

Current Plan	2024 Plan
STD Options 1 & 3	Option 5
STD Options 2 & 4	Option 6

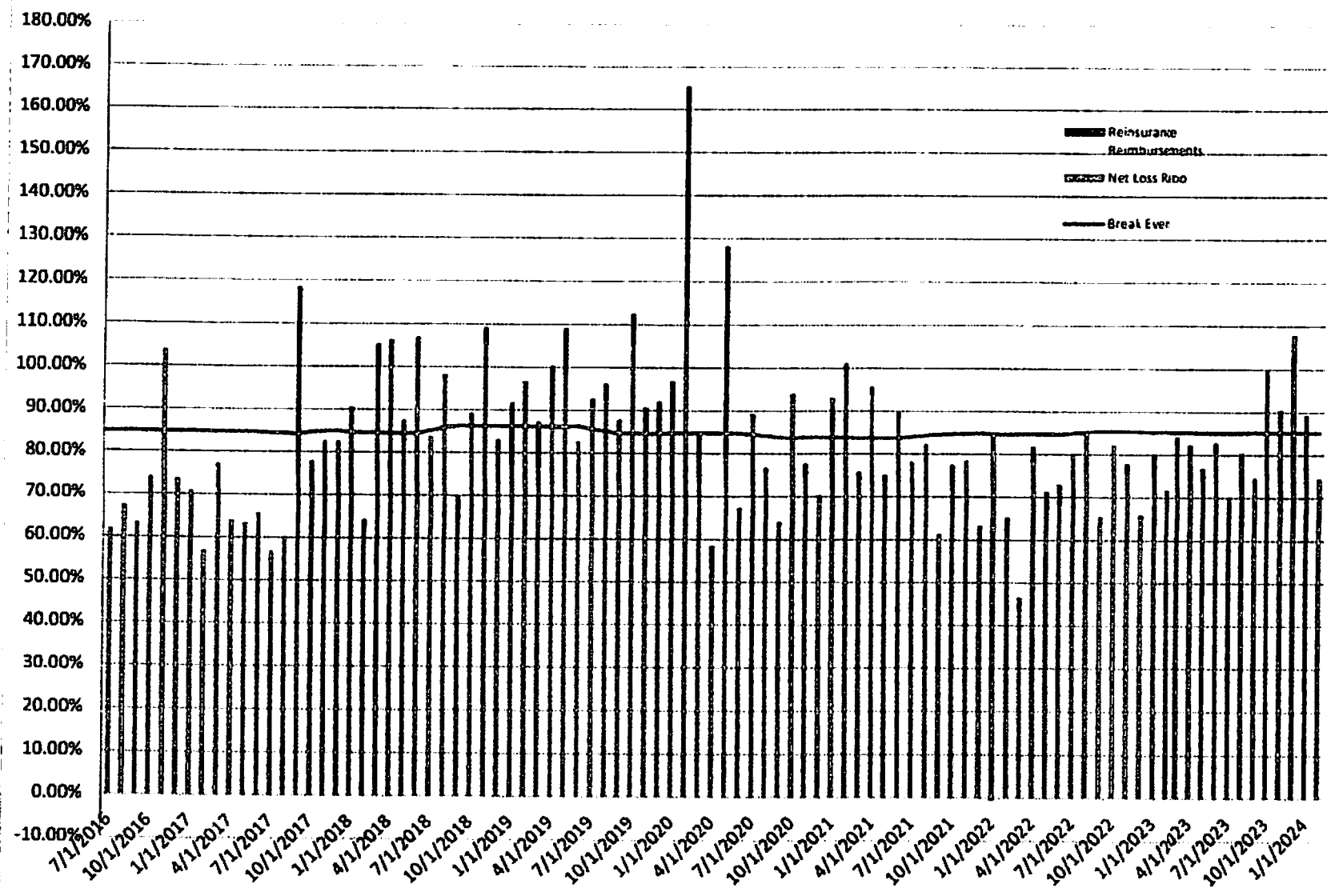
- **LTD PLANS HAVE BEEN ENHANCED!** The monthly benefit maximum is increasing from \$5,000 to \$10,000. This means that covered income will increase from \$8,333/month to \$16,667/month

ANNUAL REMINDERS

- ✓ Your agent will help your district in completing the 2024 Master Application and the renewal process.
- ✓ **If your district also participates in the OFCA benefit package, be aware the plan designs and rates are different.**

Thank you for your partnership, and the confidence you have placed in Special Districts as your health plan of choice.

SDIS - Medical/Rx/Vision/Dental Loss Ratio - (Incurred & Trended)



Master Application Instructions for 2024

NO CHANGES? 3 STEPS

1. Add district name- see Page 1, General Information
2. Check YES box- see Page 1, General Information

Renew ALL Coverages AS-IS? Yes No



3. Add contact information and sign – see Page 3, Contact Information

Any district making changes to their coverage options, please fully complete and sign the application.

NOTE: Employees who are making enrollment changes for our July 1 renewal, please submit any enrollment applications and changes by May 1, 2024.

**Please return all Master Applications by May 1, 2024
to Shelly Barker at Special Districts and your local agent.**

sbarker@sdao.com

SPECIAL DISTRICTS INSURANCE SERVICES

Master Application and Renewal Confirmation Form for Group Benefit Coverage: 2024

SDIS

SPECIAL DISTRICTS
INSURANCE SERVICES

GENERAL INFORMATION

Legal Name of Employer: _____
Business Street Address: _____
City: _____ **Zip Code:** _____ **County:** _____
Billing Address (if different than above): _____
City: _____ **State:** _____ **Zip Code:** _____
Phone No.: (____) _____ **Fax No.:** (____) _____
E-Mail Address: _____
Type of District: _____ **Federal I.D. No.:** _____ **SIC No. 9199**
Name of Contact: _____ **Title:** _____

Renew ALL Coverages AS-IS? Yes No

If you checked Yes to Renew ALL coverage AS-IS, please proceed to page 3 and complete Contact Information

Internal Use Only:

Regence Group#: _____ **Delta Dental Group#:** _____ **SDIS Group#:** _____ **WVD Group#:** _____

EXISTING INSURANCE INFORMATION

Workers Compensation / State Industrial Carrier: _____ **Policy No.:** _____
Are you replacing existing group insurance? Yes No **Carrier:** _____ **Group No.:** _____

PLAN INFORMATION

The requested effective date for the policy is _____
Hours per week employees must work to be eligible for benefits: _____ hours per week (17.5 to 30 hrs.)
Probationary Period - New Employees are eligible for coverage the first of the month following: Date of hire 30 60 days
If probationary period is "Date of hire", is an employee hired on the first calendar day of the month eligible that same day? Yes No
In addition to same-sex domestic partner coverage, employer would like to offer opposite-sex domestic partner coverage Yes No
Employer contribution toward employee premium (percent): Employee: _____ % **Dependent:** _____ %
Minimum Contribution Requirements: 75% employees & 0% dependents -OR- 50% employees & 50% dependents
Minimum Participation Requirements: Dental Only - 100% of eligible employees & 75% of eligible dependents
Medical or Medical/Dental - 100% of eligible employees & 75% of eligible dependents if less than 5 employees
75% of eligible employees & 75% of eligible dependents if 5 or more employees
Those employees that waive due to other group coverage are excluded from participation requirements.

Does your group have an HRA or HSA? Yes No If yes, what does the employer contribute to the account: \$ _____

What is the name of your current health & dental insurance company? Health _____ Dental _____

PROBATIONARY PERIOD AND PEOPLE TO BE INSURED

Applications must be submitted for all employees and dependents to be insured.

_____ Total number of employees (include those who do not qualify for coverage)
- _____ Number of On-Call, Temporary, Substitute, Leased, and Seasonal employees
- _____ Number of employees who do not qualify due to working less than minimum hours
- _____ Number of employees who do not qualify due to eligibility waiting period requirement
- _____ Number of employees waiving coverage due to other group coverage (must submit waivers)
= _____ Total actual number of eligible employees to be insured

Employees on continuation of coverage: Applications must be submitted for all employees on continuation.

NAME	CONTINUATION EFF DATE	QUALIFYING EVENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

BENEFIT PLANS REQUESTED

REGENCE MEDICAL Yes No If yes, choose a plan, or plans below.

Single Option Dual Option (Available to groups with a minimum of 10 participating employees, with no less than three on a plan.)

Blue Options – Packaged

- PPO II – \$200 deductible
- PPO IIA – \$300 deductible
- PPO III – \$500 deductible
- PPO IV – \$1,000 deductible
- PPO V – \$1,500 deductible
- PPO VI – \$2,000 deductible
- PPO VII – \$2,500 deductible

Red Options – Packaged

- PPO C – \$300 deductible
- PPO D – \$500 deductible
- PPO E – \$1,000 deductible
- PPO F – \$1,500 deductible
- PPO H – \$2,000 deductible
- PPO J – \$2,500 deductible
- PPO K – \$3,000 deductible
- PPO L – \$5,000 deductible

HSA Plans

- HSA 1 – \$3,000 deductible

All Blue, Red and HSA medical plans include pharmacy, acupuncture/chiropractic, vision and Telehealth/MDLive.

DELTA DENTAL PLAN OF OREGON DENTAL

Yes No If yes, choose a plan below.

- Constant Dental Plan 1 Preventive, \$25 deductible, \$1,500 annual maximum
- Incentive Dental Plan 2 Incentive, \$0 deductible, \$1,500 annual maximum
- Constant Dental Plan 3 Preventive, \$25 deductible, \$2,000 annual maximum
- Incentive Dental Plan 4 Incentive, \$0 deductible, \$2,000 annual maximum

NOTE: A minimum of 10 employees must be enrolled to elect "dental only" coverage.

DELTA DENTAL PLAN OF OREGON DENTAL ORTHODONTIA

Yes No

- Ortho 1,500 – 50% to \$1,500 annual max, no age limit – Only available to employers with 15 or more enrolled employees
- Ortho 2,000 – 50% to \$2,000 annual max, no age limit – Only available to employers with 15 or more enrolled employees

WILLAMETTE DENTAL GROUP PLANS

Yes No If yes, choose a plan below

- Standard Dental Plan 5 \$15 General Office Visit Copay, \$0 Deductible, No Annual Maximum, Orthodontia Co-Pay \$2,500
- Enhanced Dental Plan 6 \$15 General Office Visit Copay, \$0 Deductible, No Annual Maximum, Orthodontia Co-Pay \$1,500

Underwritten by Willamette Dental Insurance, Inc. 6950 NE Campus Way, Hillsboro, Oregon, 97124

LIFE & DISABILITY

Yes No

Group Life Insurance

- Option 1 - \$10,000
- Option 2 - \$20,000
- Option 3 - \$50,000
- Option 4 – 1 x's Salary
- Option 5 – \$100,000

Short Term Disability

- Option 5 Option 6

Long Term Disability

- Option 1
- Option 2

Select only one (applies to Long Term Disability only):

- Employer pays 100% of premium
- Employer pays 0% of premium
- Employer & Employee share premium

Termination of Coverage

Terminate the following coverage at renewal: Medical Dental All Lines of Coverage
 Other: _____

Reason: _____ Name of New Carrier: _____

DOCUMENT DISTRIBUTION

Electronic copy: An electronic copy of your member Summary Plan Description (SPD) and summary (SBC) will be emailed to you once your group has been processed. This searchable format can also be saved to your intranet or computer system for employee access.

IMPORTANT INFORMATION

Affordable Care Act – For more information on the following brief guidelines, consult with your legal or tax advisors for advice.

- **Probationary** waiting periods cannot exceed 60 calendar days. Groups may select first of the month following 1, 30, or 60 calendar days.
- Groups that have eligibility and benefit packages that favor highly compensated employees may face a penalty. You can offer coverage to all employees that meet your hourly requirement and probationary waiting period or conduct IRS **nondiscrimination** testing. Groups must set their hourly requirement at no more than 30 hours per week.
- **Medical plan packages** are packaged with ancillary benefits such as vision.
- **Pediatric vision and pharmacy** are required essential health benefits (EHB) for employers and are now in medical coverage.
- **Domestic partners** that meet certain criteria are eligible dependents. If not registered with a state, a signed affidavit must be submitted with the enrollment application.

SIGNATURE – PLEASE READ CAREFULLY

- I understand that eligibility standards must be adhered to for all employees, dependents, and owners. I agree to make all coverage options available to all eligible employees and dependents that satisfy eligibility requirements.
- If I submit my materials after the 10th of the prior month, my employees may not receive Member ID Cards before they are effective.
- I understand that I am agreeing to a 12 month contract period for the insurance coverage I have elected for my district.
- I understand that to participate in the SDIS insurance program I must agree to sign the Joinder of Trust Agreement to become a member of Special Districts Insurance Services Trust.

CONTACT INFORMATION

DISTRICT REPRESENTATIVE

Signature by: _____ Date: _____

Name (please print): _____ Title: _____

PRODUCER OF RECORD

Signature by: _____ Date: _____

Producer: _____ Producer No.: _____

Agency Address: _____

Phone No. : _____ Fax No. : _____ E-mail: _____