IBERIA PARISH SCHOOL BOARD

2020 Employee Benefits

PRESENTED BY

DJW INSURANCE

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OVERVIEW OF 2020 EMPLOYEE BENEFITS

The Iberia Parish School System provides benefit eligible employees with a comprehensive offering of core and supplemental payroll deducted insurance plans. Employees may enroll during initial eligibility within 30 days of hire date or during annual open enrollment with a January 1st effective date. Employees have the option to include most benefits as a pre-tax payroll deduction through the Cafeteria Plan.

BENEFITS	PREMIUM PAYMENTS	COVERAGE SUMMARY
GROUP HEALTH INSURANCE	EMPLOYEE & EMPLOYER PAID	Plans A & C include office-visit and prescription drug co-pays. Plan B is an affordably priced, HSA-qualified, high-deductible health plan.
DENTAL INSURANCE	EMPLOYEE PAID	Provides benefits for preventive, basic, and major services. Also covers child ortho.
VISION INSURANCE	EMPLOYEE PAID	A flexible vision plan covering exams and materials.
VOLUNTARY GROUP TERM LIFE	EMPLOYEE & EMPLOYER PAID	Each employee can buy up to $60,000; Spouse $30,000; and Child(ren) $10,000

Group Health Plan
Benefit and Rate Summary
Effective 01/01/2020

BENEFITS	PLAN A	PLAN B	PLAN C
IN-NETWORK DEDUCTIBLE	$1,500	$4,000	$3,500
IN-NETWORK FAMILY DEDUCTIBLE	$4,500	$8,000	$10,500
OUT-OF-NETWORK DEDUCTIBLE	$3,000	$8,000	$7,000
OUT-OF-NETWORK FAMILY DEDUCTIBLE	$9,000	$16,000	$21,000
IN-NETWORK / OUT-OF-NETWORK COINSURANCE	80/60	80/60	60/60
IN-PATIENT HOSPITAL CO-PAY (in addition to deductible and coinsurance)	Tier 1 $0 / Tier 2 $500 **Per Occurrence**	NA	Tier 1 $0 / Tier 2 $500 **Per Occurrence**
PCP OFFICE VISIT CO-PAY	$40	N/A	$40
CHILD CO-PAY (UNDER 19)	$0	NA	$0
SPECIALIST CO-PAY	Tier 1 $60 / Tier 2 $75	N/A	Tier 1 $60 / Tier 2 $75
URGENT CARE FACILITY	$55	NA	$55
Office visit and urgent care facility co-pays apply to in-network physician office services. Physician office services refer to covered health services for the diagnosis and treatment of a sickness or injury. The covered person will pay the office visit copayment for outpatient surgery, rehab services, major diagnostics, therapeutic services or pharmaceutical products administered in the in-network physician's office or in-network urgent care facility.			
OUT-OF-POCKET MAXIMUM	$6,350	$6,350	$7,150
FAMILY OUT-OF-POCKET MAXIMUM	$12,700	$12,700	$14,300
OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM	$12,700	$12,700	$14,000
FAMILY OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM	$25,400	$25,400	$28,000
DRUG DEDUCTIBLE	$0	Integrated	$0
DRUG CO-PAYS	$15/$35/$75	$10/$35/$60 after deductible	$15/$35/$75

EMPLOYEE MONTHLY PAYROLL DEDUCTED PREMIUMS

COVERAGE TIERS	PLAN A	PLAN B	PLAN C
EMPLOYEE ONLY	$244.00	$79.00	$188.00
EMPLOYEE & CHILDREN	$562.00	$260.00	$435.00
EMPLOYEE & SPOUSE	$700.00	$345.00	$552.00
FAMILY	$873.00	$439.00	$700.00
DUAL EMPLOYEE - FAMILY	$737.00	$306.00	$570.00

DENTAL INSURANCE

DENTAL SUMMARY

		Low Plan	High Plan
Plan Benefit			
	Type 1	100%	100%
	Type 2	80%	80%
	Type 3	N/A	50%
Deductible		$25/Calendar year	$50/Calendar year
		Waived Type 1	Waived Type 1
		$75/family	$150/family
Maximum (per person)		$750/Calendar year	$1,500/calendar year
PPO		A New Choice Plus	Passive PPO
Allowance	**Type 1**	Discounted Fee	90th U&C
	Type 2	Discounted Fee	90th U&C
	Type 3	None	90th U&C
Waiting Period		None	None
Annual Open Enrollment		Included	Included

ORTHODONTIA SUMMARY

Allowance All Plan Designs: In Network, discounted fee. Out of Network, U&C (Usual and Customary).		
Plan Benefit	No Ortho	50%
Coverage for Adults		No
Lifetime Maximum		$1,500
Waiting Period		12 months – New Enrollees Only

Monthly Rates	**Low Plan**	**High Plan**
Employee Only (EE)	$20.44	$40.60
EE + Spouse	$40.32	$76.84
EE + Children	$49.12	$76.84
EE + Family	$69.00	$128.08

DENTAL SAMPLE PROCEDURE LIST

Type 1	Type 2	Type 3
-Routine Exam (2 in 12 months) -Bitewing X-rays (1 in 12 months) -Full Mouth/Panoramic X-rays (1 in 5 years) -Periapical X-rays -Cleaning (2 in 12 months) -Fluoride for Children 13 and under (1 in 12 months) -Sealants (age 16 and under)	-Space Maintainers -Restorative Amalgams -Restorative Composites -Endodontics (surgical and nonsurgical) -Periodontics (surgical and nonsurgical) -Denture repair -Simple Extractions -Complex Extractions -Anesthesia	-Onlays -Crowns (1 in 5 years) -Crown Repair -Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Fully insured through Ameritas Insurance Company

VOLUNTARY VISION PLAN

Frequency- Once Every:	
Eye Examination inclusive of Dilation	12 months
Spectacle Lenses	12 months
Frame	24 months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 months
Contact Lenses (in lieu of eyeglasses)	12 months
Copayments	
Eye Examination	$10
Spectacle Lenses	$25
Contact Lens Evaluation, Fitting & Follow up Care	$0
Eyeglass Benefit – Frame	
Frame Allowance (Retail):	Up to $150 (Plus 20% discount)
Davis Vision Frame Collection (in lieu of Allowance)	
Fashion Level	Included
Designer Level	Included
Premier Level	$25 member charge
Eyeglass Benefit – Spectacle Lenses	**Member Charges**
Clear plastic single-vision, lined bifocal, trifocal, or lenticular lenses (any size or Rx)	Included
Tinting of Plastic Lenses	Included
Scratch-Resistant Coating	Included
Polycarbonate Lenses (Children/Adults)	$0/$30
Ultraviolet Coating	$12
Anti-Reflective Coating	$35/$48/$60
Progressive Lenses	$50/$90/$140
High-Index Lenses	$55
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch Protection Plan: Single Vision/Multifocal Lenses	$20/$40
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lenses: Materials Allowance	Up to $130 (Plus 15% discount)
Evaluation, Fitting & Follow-Up Care – Standard	
Evaluation, Fitting & Follow-Up Care – Specialty	Up to $60 allowance (Plus 15% discount)
Collection Contact Lenses: Materials	
Disposable: up to	8 boxes/ multi-packs
Plan Replacement: up to	4 boxes/ multi-packs
Evaluation, Fitting & Follow-Up Care	Included

Out-of-Network Reimbursement Schedule: up to

Eye Examination: $30	Single Vision Lenses: $25	Trifocal Lenses: $45
Frame: $30	Bifocal/Progressive Lenses: $35	Lenticular Lenses: $60
Elective Contact Lenses: $75	Visually Required Contact Lenses: $225	

Employee Only: $6.33
Employee + Family: $15.24

VOLUNTARY GROUP TERM LIFE

This coverage provides financial protection for you and your loved ones. If you enroll as a new employee during your initial eligibility, your acceptance is guaranteed. Written through Trustmark Life Insurance Company.

Life Benefit	Employee	Spouse	Dependent
Amount	Choice of $10,000 increments up to $60,000	Choice of $5,000 increments up to $30,000	**No benefit**: 0 to 14 days **$100**: From age 14 days to 6 months **$10,000**: 6 months to age 26
Minimum amount	$20,000	$10,000	$10,000
Maximum amount	$60,000	$30,000	$10,000
Benefit Reduction			
Age 65	35% of original amount	35% of original amount	
Age 70	50% of original amount	50% of original amount	

EMPLOYEE PAYROLL DEDUCTED RATES

BENEFIT AMOUNT AGE BAND	$20,000	$30,000	$40,000	$50,000	$60,000
Less than 30	$0.60	$0.90	$1.20	$1.50	$1.80
30-39	$3.80	$5.70	$7.60	$9.50	$11.40
40-44	$4.60	$6.90	$9.20	$11.50	$13.80
45-49	$6.20	$9.30	$12.40	$15.50	$18.60
50-54	$9.00	$13.50	$18.00	$22.50	$27.00
55-59	$17.80	$26.70	$35.60	$44.50	$53.40
60-64	$22.20	$33.30	$44.40	$55.50	$66.60
65-69	$22.60	$33.90	$45.20	$56.50	$67.80
70 and above	$37.40	$56.10	$74.80	$93.50	$112.20

SPOUSE RATES (BASED ON EMPLOYEE AGE)

BENEFIT AMOUNT AGE BAND	$10,000	$15,000	$20,000	$25,000	$30,000
Less than 30	$4.40	$6.60	$8.80	$11.00	$13.20
30-39	$4.50	$6.75	$9.00	$11.25	$13.50
40-44	$5.30	$7.95	$10.60	$13.25	$15.90
45-49	$6.40	$9.60	$12.80	$16.00	$19.20
50-54	$8.20	$12.30	$16.40	$20.50	$24.60
55-59	$11.00	$16.50	$22.00	$27.50	$33.00
60 and above	$17.00	$25.50	$34.00	$42.50	$51.00

DEPENDENT RATES

AGE	BENEFIT AMOUNT	MONTHLY PREMIUM
14 days to 6 months	$100	$2.20
6 months to 19 years old (age 25 if full time student)	$10,000	

For more information or assistance with your employee benefits, contact:

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