For the June 1, 2020 through May 31, 2021 benefit plan year, I select the following coverage:

**Medical Insurance**: Please check one option for Medical

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Change Per Pay Period +15%** | **PPO** | **Monthly Cost for Plan Year 2020** | **Employee Portion Monthly** | **Employee Portion per pay check** |  |
| **+6.85** | Employee | 880.00 | 88.00 | 44.00 | 10% |
| **+94.00** | Employee & Spouse | 2408.00 | 1204.00 | 602.00 | 50% |
| **+82.75** | Employee & Child(ren) | 2122.00 | 1061.00 | 530.50 | 50% |
| **+101.75** | Family | 2609.00 | 1304.50 | 652.25 | 50% |
|  | Medicare Supplement - Single | 880.00 |  |  |  |
|  | Medicare Supplement - Employee & Spouse | 1760.00 |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **+5.50%** | **HMO** | **Monthly Cost for Plan Year 2020** | **Employee Portion Monthly** | **Employee Portion per pay check** |  |
| **+1.66** | Employee | 619.50 | 61.95 | 30.98 | 10% |
| **+15.61** | Employee & Spouse | 1197.44 | 598.72 | 299.36 | 50% |
| **+14.98** | Employee & Child(ren) | 1149.12 | 574.56 | 287.28 | 50% |
| **+23.17** | Family | 1777.86 | 888.93 | 444.47 | 50% |
|  | Medicare Supplement - Single | 619.50 |  |  |  |
|  | Medicare Supplement - Employee & Spouse | 1197.44 |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **+15%** | **High Deductible Health Plan** | **Monthly Cost for Plan Year 2020** | **Employee Portion Monthly** | **Employee Portion per pay check** |  |
| **+6.20** | Employee | 793.00 | 79.30 | 39.65 | 10% |
| **+84.50** | Employee & Spouse | 2169.00 | 1084.50 | 542.25 | 50% |
| **+74.50** | Employee & Child(ren) | 1912.00 | 956.00 | 478.00 | 50% |
| **+91.75** | Family | 2351.00 | 1175.50 | 587.75 | 50% |
|  | Medicare Supplement - Single | 793.00 |  |  |  |
|  | Medicare Supplement - Employee & Spouse | 2169.00 |  |  |  |
|  |  |  |  |  |  |
|  | **No Coverage** |  |  |  |  |

**Dental Insurance:** Please check one

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Increase**  **1.30%** | **Dental - PPO** | **Monthly Cost for Plan Year 2020** | **Employee Portion Monthly** | **Employee Portion per pay check** |
| **+.05** | Employee | 45.00 | 4.50 | 2.25 |
| **+.50** | Family | 130.00 | 65.00 | 32.50 |
|  | No Coverage |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Dental –HMO Plan 285** | **Monthly Cost for Plan Year 2020** | **Employee Portion Monthly** | **Employee Portion per pay check** |
| **N/C** | Employee | $16.31 | $1.63 | $0.82 |
| **N/C** | Family | $38.23 | $19.12 | $9.56 |
| **N/C** | No Coverage |  |  |  |

**Vision Insurance:** Please check one

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Vision** | **Monthly Cost for Plan Year 2020** | **Employee Portion Monthly** | **Employee Portion per pay check** |
| **N/C** | Employee | $4.19 | $0.42 | $0.21 |
| **N/C** | Family | $11.72 | $5.86 | $2.93 |
|  | No Coverage |  |  |  |

**Flexible Spending Account:**

**\_\_\_\_\_** Yes, I select establishing or continuing a flexible spending account for medical.

\_\_\_\_\_ No, I decline establishing a flexible spending account this year.

The above coverage selections are for the plan year of June 1, 2020 through May 31, 2021. Changes during the plan year are allowed for qualifying major life changing events only. Premiums for these plans are deducted pre-tax for the election year.

Employee Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Revised 3-10-20**