Educational Partnerships, Inc.

Plan Selection Form

October 1, 2015 - September 30, 2016

Employee Name: _____

Section 1: MEDICAL/RX BENEFITS			**MEDICAL/RX**
MEDICAL OPTION: Priority Health POS *$20 Office Visit Copay* *$35 Specialist Copay* *$75 Urgent Care Copay* *$250/$500 Deductible* *20% Coinsurance* *$10/$40 /$80 RX Copay*	**Monthly Premium** Single Two Person Family Waiving Medical**	 $494.44 ☐ $1,185.44 ☐ $1,419.31 ☐ N/A ☐	$ _____ Monthly Premium
*Family premium rates do not include ACA Fees equal to $5.42 per family member, fees are the employee's responsibility			
Section 2: DENTAL			**DENTAL**
Delta Dental *Chamber Plan MC100* *$50/$150 Deductible* *100/90/60/50* *$1000 Annual Max* *$1000 Ortho Max*	Single Two Person Family Waiving Dental**	$38.90 ☐ $72.58 ☐ $136.83 ☐ N/A ☐	$ _____ Monthly Premium
Section 3: VISION			**VISION**
VSP Plan - Choice *$10 Eye Exam Copay* *$25 Materials Copay* *Exam - 1 per 12 Months* *Lenses - 1 per 12 Months* *Frame - 1 per 12 Months*	**Monthly Premium** Single Two Person Family Waiving Vision**	 $9.00 ☐ $13.50 ☐ $24.00 ☐ N/A ☐	$ _____
Section 4: Monthly Premium for Medical and Dental			
Add the monthly premiums from Sections 1 + Section 2 + Section 3. **Monthly Premium for Medical, Dental & Vision:**			$ _____ Monthly Premium
Section 5: Monthly Benefit Allowance			
Your Monthly Benefit Allowance: **Elections that cost less than $500 will not result in an increase to your monthly salary.**			**$500**
Section 6: Monthly Pre-Tax Deduction for Medical and Dental			
To determine your Monthly Pre-Tax Deduction for Medical, Dental & Vision, please subtract Section 5 ($500) from Section 4. There is no cash value to the Monthly Benefit Allowance. If the amount in Section 5 is less than $0, please insert $0 for the Pre-Tax Deduction amount for Medical & Dental.			**TOTAL: $** _____ Pre-Tax Deduction for Medical and Dental
All eligible full-time employees will receive life insurance at not cost to the employee **LIFE/AD&D coverage - $10,000 benefit,** **Short Term Disability/Long Term Disability**			**Employer Paid**

****Cash-In-Lieu of Medical Insurance**

Employees waiving medical, dental, & vision coverage will receive $4000 to be paid in 23 installments.

1. In lieu of medical coverage, I will be paid $173.91 to be included in each paycheck.
2. This option is a taxable benefit and is subject to FICA, federal, state, and city tax.
3. If during the plan year I lose my other medical coverage and want to establish coverage through Educational Partnerships Inc., I must notify the HR Administrator **within 30 days of lost coverage**. I will be required to provide proof of loss of coverage (ie. insurance cancellation notice, divorce decree, etc…), and my enrollment will be subject to the plan's eligibility and enrollment rules. I will lose 100% of this bonus.

Signature: _____ **Date:** _____

I have received and read all of the materials explaining this plan. I understand that I am making an election concerning my benefits for the full plan year and authorize any required salary reduction in accordance with my elections above. My elections are binding subject to any changes required to comply with federal law, such as a change in my family status. A change in family status may include, but is not limited to, marriage; divorce; death of a spouse or dependent; birth or adoption of a child; or a change in my (or my spouse's) employment status. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I hereby apply for the options listed above.

Signature: _____ **Date:** _____