Educational Partnerships, Inc. 2016-2017 Plan Section Form
Medical Renewal 11/1/2016-10/31/2017; Medical Dental Renewal 10/1/2016-9/30/2017

Employee Name:

Section 1: Medical/RX Benefits Provided by Priority Health POS				MEDICAL
Copays:		RATES		
$20/Office	Single	$506.53	☐	
$35/Specialist	Two Person	$1,214.71	☐	$_____
$75/$150 Urgent Care/Hospital	Family	$1,461.90	☐	Monthly Premium
$10/$40/$80 Prescriptions	Waiving Medical	$0.00	☐	
20% Coinsurance	*ACA taxes for family rate not represented and will be added to deductions			
Section 2: Dental Benefits Provided by Delta Dental PPO				DENTAL
$50/$100 Deductible		RATES		
100/90/60/50	Single	$38.90	☐	
$1000 Annual Max	Two Person	$72.58	☐	$_____
$1000 Ortho Max	Family	$136.83	☐	Monthly Premium
	Waiving Dental	$0.00	☐	
Section 3: Vision Benefits Provided by VSP Plan-Choice				VISION
$10 Eye Exam Copay		RATES		
$25 Materials Copay	Single	$9.00	☐	
Exam-1 per 12 months	Two Person	$13.50	☐	$_____
Lenses-1 per 12 months	Family	$24.00	☐	Monthly Premium
Frame-1 per 12 months	Waiving Vision	$0.00	☐	
Section 4: Subtotal of Coverage (ADD Section 1 +Section 2+Section 3)				**$_____**
Section 5: Monthly Benefit Allowance (paid by Employer)				**$500.00**
Section 6: Total Monthly Pre Tax Deduction (Subtract Section 5 from Section 4)				**$_____**
Section 7: Total Deduction per Pay Check (Divide Section 6 by 2)				**$_____**

After one calendar year of employment all employees will receive $10,000 Life/AD&D Insurance, Short term disability and long term disability. This is 100% funded by the employer.

I have received and read all of the materials explaining this plan. I understand 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 including but not limited to marriage, divorce, death of a covered family member, birth/adoption, or a change in my spouse's employment status. I understand that the costs of this coverage may be adjusted from time to time to reflect changes in rates charged by the carriers. I here by apply for the options listed above.

Signature: _____ Date: _____

Cash-In-Lieu of Benefits

I understand that I must waive medical, dental and vision coverage to qualify for this stipend. I understand that I will be paid $4,000 in 24 equal installments of $166.67 over my contract year. Beginning on 9/16/2016 and ending on 9/1/2017. I understand that if I leave my employment before my contract year is over that I am not entitled to the remaining balance of my stipend. I understand that if during the plan year, I have a qualifying event and need to sign up for coverage through EPI, I must notify the H.R. Administrator within 30 days of the event, and I will be required to reimburse all portions of this stipend already paid. My signature below indicates that I have read, this disclaimer and agree to the conditions.

Signature: _____ Date: _____