

EMAN Plan Selection Form

November 1, 2020 - October 31, 2021

Employee Name _____

Section 1: Medical Benefits	Medical
Medical HAP HMO w/44North HRA and ARORx Deductible: \$500/1,000 Coinsurance: 10% Office Visit \$20/Specialist Visit \$40 Urgent Care/ER: \$50/\$150 after deductible RX Plan: \$4/\$15/\$40/\$80/20% (\$200 max) / 20% (\$300 max)	Single \$394.62 <input type="checkbox"/> Two Person \$922.66 <input type="checkbox"/> Family \$1,148.95 <input type="checkbox"/> Waiving n/a <input type="checkbox"/> \$ _____ Total Medical
Section 2: Dental	Dental
MI Chamber Plan / Delta Dental PPO Deductible: \$50/\$150 100%/90%/60%/50% Annual Maximum: \$1,000 Ortho Lifetime Maximum: \$1,000 *Employees waiving medical & dental coverage will receive an opt out Credit of \$2,000 per year. Please complete the "Cash in Lieu" section below and include a copy of proof of other coverage	Single \$35.90 <input type="checkbox"/> Two Person \$66.97 <input type="checkbox"/> Family \$126.27 <input type="checkbox"/> Waiving n/a <input type="checkbox"/> \$ _____ Total Dental
Section 3: Monthly Premium for Medical and Dental	
Add the Monthly Premiums from Section 1 and Section 2	\$ _____ Total Med & Den
Section 4: Monthly Benefit Allowance	
Your Monthly Benefit Allowance:	(\$800)
Section 5: Monthly Pre-Tax Deduction for Medical and Dental	
To determine your Monthly Pre-Tax Deduction for Medical & Dental, please subtract Section 4 (\$800) from Section 3. 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 and Dental	\$ _____ Total Pre-Tax Med/Den
Section 6: Vision	
Voluntary MI Chamber / VSP Eye Exam copay: \$20 Materials copay: \$20 Exam limit: 1 per 12 months Lenses Limit: 1 per 12 months Frame Limit: 1 per 24 months *Please note: This is a voluntary vision plan. Benefit Allowance cannot be used toward the vision premiums. The premiums are paid in full by the employee.	Single \$9.06 <input type="checkbox"/> Two Person \$13.28 <input type="checkbox"/> Family \$23.82 <input type="checkbox"/> Waiving n/a <input type="checkbox"/> \$ _____ Total
Section 7: Total Monthly Pre-Tax Deduction for Medical, Dental and Vision	
To determine your TOTAL Monthly Pre-Tax Deduction, please add Section 5 and Section 6	\$ _____ Total
Short Term Disability through Lincoln	
Cash-in-Lieu of Medical Insurance: To be eligible, you must provide written proof of other health care coverage. The required proof is an official document verifying you are insured under a group health insurance plan. For example, a letter or official website document from your spouse's employer stating you are currently covered under their health insurance plan, which lists your name as an eligible dependent and the effective date of coverage. 1. You will be paid opt out cash at the end of the contract, based on my selection above. 2. This option is a taxable benefit and is subject to FICA, federal, state and city tax. 3. You must be an active employee for 12 months before you receive \$2,000 cash in lieu. 4. If during the plan year, you lose your other medical coverage and want to establish coverage through EMAN, Inc, You must notify the HR Administrator within 30 days of lost coverage. You will be required to provide proof of loss of coverage (ie. insurance cancellation notice, divorce decree, etc...). and your enrollment will be subject to the plan's eligibility and enrollment rules.	
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 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 changes in rates charged by the carriers. I hereby apply for the options listed above.	
Signature _____	Date _____