

Education Management & Network, Inc.

November 1, 2025 - October 31, 2026

Employee Name _____

Section 1: Medical Benefits	Medical Total												
Medical HAP HMO													
Deductible: \$500 / \$1,000 Coinsurance: 10% Office Visit \$20 / Specialist Visit \$40 Urgent Care \$75 / ER \$250 after deductible RX Plan: \$5/\$15/\$20/\$40/20%/50%	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Single</td> <td style="width: 30%;">\$518.61</td> <td style="width: 40%;"><input type="text"/></td> </tr> <tr> <td>Two Person</td> <td>\$1,244.66</td> <td><input type="text"/></td> </tr> <tr> <td>Family</td> <td>\$1,555.82</td> <td><input type="text"/></td> </tr> <tr> <td>Waiving</td> <td>N/A</td> <td><input type="text"/></td> </tr> </table>	Single	\$518.61	<input type="text"/>	Two Person	\$1,244.66	<input type="text"/>	Family	\$1,555.82	<input type="text"/>	Waiving	N/A	<input type="text"/>
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Two Person	\$1,244.66	<input type="text"/>											
Family	\$1,555.82	<input type="text"/>											
Waiving	N/A	<input type="text"/>											
\$ _____													
Section 2: Dental	Dental Total												
MI Chamber Plan / Delta Dental PPO													
Deductible: \$50 / \$150 100% / 90% / 60% / 50% Annual Maximum: \$1,000 Lifetime Ortho Maximum: \$1,000	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Single</td> <td style="width: 30%;">\$35.81</td> <td style="width: 40%;"><input type="text"/></td> </tr> <tr> <td>Two Person</td> <td>\$66.80</td> <td><input type="text"/></td> </tr> <tr> <td>Family</td> <td>\$125.95</td> <td><input type="text"/></td> </tr> <tr> <td>Waiving</td> <td>N/A</td> <td><input type="text"/></td> </tr> </table>	Single	\$35.81	<input type="text"/>	Two Person	\$66.80	<input type="text"/>	Family	\$125.95	<input type="text"/>	Waiving	N/A	<input type="text"/>
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Waiving	N/A	<input type="text"/>											
<i>*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.</i>													
\$ _____													
Section 3: Monthly Premium for Medical and Dental	Total Medical & Dental												
Add the Monthly Premiums from Section 1 and Section 2	\$ _____												
Section 4: Monthly Benefit Allowance	Monthly Benefit Allowance Total												
Your Monthly Benefit Allowance:	(\$1,125)												
Section 5: Monthly Pre-Tax Deduction for Medical and Dental	Total Pre-Tax Medical & Dental												
To determine your Monthly Pre-Tax Deduction for Medical & Dental, please subtract Section 4 (\$1,125) 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.	\$ _____												
Section 6: Vision	Vision Total												
Voluntary MI Chamber / VSP													
Eye Exam: \$20 Copay - Materials: \$20 Copay Exam Limit: 1 per 12 months Lenses Limit: 1 per 12 months Frame Limit: 1 per 24 months	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Single</td> <td style="width: 30%;">\$9.06</td> <td style="width: 40%;"><input type="text"/></td> </tr> <tr> <td>Two Person</td> <td>\$13.28</td> <td><input type="text"/></td> </tr> <tr> <td>Family</td> <td>\$23.82</td> <td><input type="text"/></td> </tr> <tr> <td>Waiving</td> <td>N/A</td> <td><input type="text"/></td> </tr> </table>	Single	\$9.06	<input type="text"/>	Two Person	\$13.28	<input type="text"/>	Family	\$23.82	<input type="text"/>	Waiving	N/A	<input type="text"/>
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Two Person	\$13.28	<input type="text"/>											
Family	\$23.82	<input type="text"/>											
Waiving	N/A	<input type="text"/>											
<i>*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.</i>													
\$ _____													
Section 7: Total Monthly Pre-Tax Deduction for Medical, Dental and Vision	Monthly Pre-Tax Total												
To determine your TOTAL Monthly Pre-Tax Deduction, please add Section 5 and Section 6	\$ _____												
Short Term Disability through Lincoln	Employer Pd												
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 degree, 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 _____													