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	Single	$394.62	☐	
Coinsurance: 10%	Two Person	$922.66	☐	
Office Visit $20/Specialist Visit $40	Family	$1,148.95	☐	
Urgent Care/ER: $50/$150 after deductable	Waiving	n/a	☐	$_____
RX Plan: $4/$15/$40/$80/20% ($200 max) / 20% ($300 max)				Total Medical
Section 2: Dental				Dental
MI Chamber Plan / Delta Dental PPO				
Deductible: $50/$150	Single	$35.90	☐	
100%/90%/60%/50%	Two Person	$66.97	☐	
Annual Maximum: $1,000	Family	$126.27	☐	
Ortho Lifetime Maximum: $1,000	Waiving	n/a	☐	$_____
				Total Dental
*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				
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	Single	$9.06	☐	
Materials copay: $20	Two Person	$13.28	☐	
Exam limit: 1 per 12 months	Family	$23.82	☐	
Lenses Limit: 1 per 12 months	Waiving	n/a	☐	$_____
Frame Limit: 1 per 24 months				Total
*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.				
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				**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_____