

Medical Benefits	Plan 1	Plan 2	Plan 3 (HSA)
Member Coinsurance	20%	20%	0%
Deductible			
Individual	\$2,000	\$3,500	\$5,500
Family	\$4,000	\$7,000	\$11,000
Out-of-Pocket Max			
Individual	\$6,000	\$7,000	\$7,500
Family	\$12,000	\$14,000	\$15,000
Physician Services			
Primary Care	\$25 Copay	\$35 Copay	Deductible
Routine Preventative	100% Covered	100% Covered	100% Covered
Specialist	\$75 Copay	\$75 Copay	Deductible
Hospital Services			
Inpatient Hospital	Deductible + 20%	Deductible + 20%	Deductible
Physician Services	Deductible + 20%	Deductible + 20%	Deductible
Outpatient Surgery	Deductible + 20%	Deductible + 20%	Deductible
Outpatient Diagnostics	Deductible + 20%	Deductible + 20%	Deductible
Urgent Care	\$75 Copay	\$75 Copay	Deductible
Emergency Room	\$300 Copay + 20%	\$300 Copay + 20%	Deductible + \$500 Copay
Prescription Card			
Retail	\$3 / \$10 / \$50 / \$80 / 20% to \$250 / 40% to \$500	\$3 / \$10 / \$50 / \$80 / 20% to \$250 / 40% to \$500	Deductible + \$3 / \$10 / \$50 / \$100 / 20% to \$250 / 40% to \$500
Mail Order (90 Day Supply)	2x Retail Copay	2x Retail Copay	Deductible + 2x Retail Copay
Employee Cost per Paycheck			
Employee Only	<input type="checkbox"/> \$91.10	<input type="checkbox"/> \$59.66	<input type="checkbox"/> \$51.29
Employee + Spouse	<input type="checkbox"/> \$183.29	<input type="checkbox"/> \$119.70	<input type="checkbox"/> \$102.37
Employee + Child(ren)	<input type="checkbox"/> \$172.23	<input type="checkbox"/> \$112.49	<input type="checkbox"/> \$96.24
Family	<input type="checkbox"/> \$283.77	<input type="checkbox"/> \$185.14	<input type="checkbox"/> \$158.05
WAIVE MEDICAL COVERAGE	<input type="checkbox"/>		
	DENTAL	VISION	
Employee Cost per Paycheck			
Employee Only	<input type="checkbox"/> \$3.67	<input type="checkbox"/> \$0.85	
Employee + Spouse	<input type="checkbox"/> \$6.99	<input type="checkbox"/> \$1.62	
Employee + Child(ren)	<input type="checkbox"/> \$9.43	<input type="checkbox"/> \$1.70	
Family	<input type="checkbox"/> \$12.69	<input type="checkbox"/> \$2.50	
WAIVE COVERAGE	<input type="checkbox"/>	<input type="checkbox"/>	
Check the box next to the cost for the plan you want above, then fill in the information below.			

PRINT NAME

SIGNATURE

DATE