HANCOCK COUNTY GOVERNMENT 2018 Plan Election Form

Employee Information

LAST NAME:_____ **FIRST NAME, M.I.**:_____

EMPLOYEE DATE OF BIRTH:_____ **EMPLOYEE LAST 4 of SSN:**_____

HOME ADDRESS:_____**CITY**:_____ **STATE:**_____ **ZIP**:_____

	Plan 1 - PPO	**Plan 2 - HSA**
	Network / Non-Network	*Network / Non-Network*
Deductible		
Individual	$1,500 / $2,000	$3,000 / $6,000
Family	$3,000 / $6,000	$6,000 / $12,000
Coinsurance	20% / 50%	0% / 30%
Out of Pocket Max		
Individual	$4,000 / $8,000	$3,000 / $12,000
Family	$8,000 / $16,000	$6,000 / $24,000
Office Visit	$40 / 50%	$0% / 30%
Rx Copays		
Retail (30 day supply)		
Generic	$20 / 50% min $40	
Brand	$35 / 50% min $40	Coinsurance
Non-Formulary	$50 / 50% min $40	
Mail Order (90 day supply)		
Generic	$20 / Not Covered	
Brand	$70 / Not Covered	Coinsurance
Non-Formulary	$120 / Not Covered	

ALL CONTRIBUTIONS ARE SEMI-MONTHLY. Please refer to the 2018 Summary of Rates for the correct contribution amounts. All contributions are withheld semi-monthly, one month in advance.

MEDICAL COVERAGE

PLAN SELECTION

☐ PLAN 1 (CO-PAY)

☐ PLAN 2 (HSA)

☐ NO COVERAGE –Waive Coverage

COVERAGE TYPE & CONTRIBUTION AMOUNTS

☐ EE ONLY $_____ ☐ EE & CHILDREN $_____

☐ EE & SPOUSE $_____ ☐ FAMILY $_____

FLEXIBLE SPENDING ACCOUNT

☐ I wish to enroll in the Flexible Spending Account for 2017 (Please complete the OptumHealth form)

VISION COVERAGE & CONTRIBUTION AMOUNTS – **ALL MUST** Complete new Vision Application ☐ NO VISION COVERAGE SELECTED

☐ EE ONLY $_____ ☐ EE & SPOUSE $_____ ☐ EE & CHILDREN $_____ ☐ FAMILY $_____

DENTAL COVERAGE & CONTRIBUTION AMOUNT ☐ NO DENTAL COVERAGE SELECTED

☐ EE ONLY $_____ ☐ EE & SPOUSE $_____ ☐ EE & CHILDREN $_____ ☐ FAMILY $_____

WELLNESS COMMITMENT

In order to receive the reduced medical contributions you must agree to participate in either one or both of the wellness options listed below. For the annual wellness checkup you will be required to submit a form signed by your physician that this has been completed for you and any dependents covered under the medical policy. For the tobacco free program you agree that you will not use tobacco products while covered under the plan. Non-compliance after commitment, without proper notification, is grounds for loss of coverage. Please check the box for the wellness commitment that you are agreeing to.

☐ **ANNUAL PHYSICAL EXAM** (for all covered members) ☐ **TOBACCO FREE** (for all covered members) ☐ **NO WELLNESS COMMITMENT**

The following items need to be returned with this election form to Mary McCoy, Payroll/HR Deputy. Please return in sealed envelope.

1. **Certification of spousal eligibility** (if you have a spouse covered on the medical plan)
2. **HSA Direct Deposit From** (if you are electing HSA contributions payroll deducted)
3. **OptumHealth Enrollment Form** (if you want to participate in the Flexible Spending Account)

_____ _____

Employee Signature **Date**