Employee Medical, Dental and Vision Benefit Selection Sheet for
Hellebusch Tool & Die, Inc. 10/1/2025 - 9/30/2026

Please check the boxes of the plans you are choosing below

Medical Benefits (In Network Benefits shown)	Anthem HSA Blue Preferred & Blue Access Choice Network Plan 1- BP HSA / Plan 2- BAC HSA	Anthem PPO Blue Preferred & Blue Access Choice Network Plan 3- BP PPO / Plan 4- BAC PPO
Lifetime Maximum	Unlimited	Unlimited
Deductible	Embedded	Embedded
Individual	$3,300	$1,000
Family	$6,600	$2,000
Co-Insurance	20%	20%
Max Out of Pocket		
Individual	$7,500	$6,850
Family	$15,000	$13,700
Preventive Office Visit	$0	$0
Dr.'s Office Visit	20% Coinsurance AD	$30 Primary Copay $70 Specialist Copay
Emergency Room	20% Coinsurance AD	$300 Copay AD
Urgent Care	20% Coinsurance AD	$50 Copay
In Patient Hosp	20% Coinsurance AD	20% Coinsurance AD
Out Patient Svcs		
Diagnostic Labs (Not Major)	20% Coinsurance AD	$0 Copay
Diagnostic X-Ray (Not-Major)		
Same Day Surgery		20% Coinsurance AD
Major Diagnostics		
Drug Card		
	Must meet Medical Deductible	
Tier 1 - Generic	$10 Copay AD	$10 Copay
Tier 2 - Brand Name	$35 Copay AD	$35 Copay
Tier 3 - Non-Preferred	$75 Copay AD	$75 Copay
Tier 4 - Specialty - Brand Name	25% Coinsurance AD up to $350 max/Rx	25% Coinsurance up to $350 max/Rx

Per-Pay Period Rates - Check Election Choice

BP = Blue Preferred Network (Narrow Network-NO BJC/Wash U) -BAC = Blue Access Choice Network (Full Network)

	Plan 1 - BP HSA		Plan 2 - BAC HSA		Plan 3 - BP PPO		Plan 4 - BAC PPO	
Employee	$24.95		$36.67		$42.91		$56.89	
Employee & Spouse	$47.49		$72.07		$84.81		$114.95	
Employee & Child(ren)	$42.74		$64.15		$77.57		$104.47	
Family	$63.40		$94.45		$114.00		$152.77	
I wish to WAIVE Medical coverage								

Dental Benefits (In Network Benefits shown)	Anthem Essential Choice	
Preventive	100% / 100$	
Basic	80% / 80%	
Major	50% / 50%	
Orthodontics *(No Wait)*	50% / 50%	
Deductible (Ind/Fam) **Waived Preventive**	$50/$150	
Annual Maximum Benefits ***Rollover Included***	$1,000	
Endodontics & Periodontics	Basic	
Oral Surgery	Major	
Per-Pay Period Rates - Check Election Choice		
Employee	$2.07	
Employee & Spouse	$4.11	
Employee & Child(ren)	$4.68	
Family	$7.68	
I wish to WAIVE Dental coverage		

Voluntary Vision Benefits (In Network Benefits shown)	Anthem FS.B.10.25.150.150	
Exam/Materials Copay	$10 / $25	
Exam/Lense/Frame Frequency	12/12/24	
Frame/Contact Allowance	$150 / $150	
Per-Pay Period Rates - Check Election Choice		
Employee	$1.50	
Employee & Spouse	$2.84	
Employee & Child(ren)	$3.33	
Family	$4.69	
I wish to WAIVE Vision coverage		

Per IRS Regulations, a Qualified High Deductible Health Plan that must be used in conjunction with a Health Savings Account (HSA), must have NO first dollar expenses, except for allowable Preventive Services. This means that on the HSA Qualified plan above, the member must meet the full deductible before any cost sharing. The copays & coinsurance listed "kick" in AFTER the deductible is met (AD).

HSA Limits 2025/2026 Individual $4300/$4400 Family $8550/$8750
(55+ $1000 catch up contribution)

HTD will contribute, one time only, start-up funding (per election)
Employee Only: $200 / Employee + Spouse: $300 / Employee &Child(ren): $300 / Family: $500

Please indicate your HSA Election:

_____ **I would like to enroll in the H.S.A account on a pre-tax basis.**

I would like to contribute $_____ per pay period from my paycheck for the rest of the calendar year.
Beginning on 1/1/25, I would like to contribute the following amount per pay period: $_____

_____ **I do not wish to enroll in the H.S.A account at this time.**

If you wish to enroll in Voluntary Life or Long Term Disability coverage, see Cathy Hunter for the appropriate forms.
NOTE: Be sure to keep Beneficiary information up to date. Please see Cathy Hunter to make any changes.

Mutual of Omaha Voluntary Life and AD&D (Check Election Choice)	
Enroll in Voluntary Life coverage	
I wish to WAIVE Voluntary Life coverage	

Mutual of Omaha Voluntary Long Term Disability (Check Election Choice)	
Enroll in Voluntary LTD coverage	
I wish to WAIVE Voluntary LTD coverage	

Please complete Employee Information & Dependent enrollment and sign on the back of this form.

All forms are to be returned to HR as soon as possible.
Elections will take effect on the first day of the month following 30 days of hire.

Hellebusch Tool & Die
Enrollment Information

Employee Information

Name:______________________ Date of Birth:____________ Gender: M / F SSN:__________________

Address:______________________________ City: ____________ State:________ Zip:__________

Date of Hire:____________ Occupation:____________________ Annual Salary:____________

Phone Number:________________ Home / Cell E-Mail:______________________________

Plan Elections

Medical		Dental		Vision		Voluntary Life		Voluntary LTD	
Enroll		Enroll		Enroll		Enroll		Enroll	
Circle Plan Option 1 2 3 4		Waive		Waive		Waive		Waive	
Waive									

Dependent Information (only those to be enrolled)

Name:______________________ Date of Birth:____________ Gender: M / F SSN:__________________

Relationship:____________________

Same Address: Y / N Address if Different from Above:______________________________

Name:______________________ Date of Birth:____________ Gender: M / F SSN:__________________

Relationship:____________________

Same Address: Y / N Address if Different from Above:______________________________

Name:______________________ Date of Birth:____________ Gender: M / F SSN:__________________

Relationship:____________________

Same Address: Y / N Address if Different from Above:______________________________

Name:______________________ Date of Birth:____________ Gender: M / F SSN:__________________

Relationship:____________________

Same Address: Y / N Address if Different from Above:______________________________

Name:______________________ Date of Birth:____________ Gender: M / F SSN:__________________

Relationship:____________________

Same Address: Y / N Address if Different from Above:______________________________

Plan Elections

Medical		Dental		Vision		Voluntary Life	
Enroll		Enroll		Enroll		Enroll	
Waive		Waive		Waive		Waive	

Medical		Dental		Vision		Voluntary Life	
Enroll		Enroll		Enroll		Enroll	
Waive		Waive		Waive		Waive	

Medical		Dental		Vision		Voluntary Life	
Enroll		Enroll		Enroll		Enroll	
Waive		Waive		Waive		Waive	

Medical		Dental		Vision		Voluntary Life	
Enroll		Enroll		Enroll		Enroll	
Waive		Waive		Waive		Waive	

Medical		Dental		Vision		Voluntary Life	
Enroll		Enroll		Enroll		Enroll	
Waive		Waive		Waive		Waive	

Additional Employee & Dependent Information

Medical Waiver Reason: (Circle)	Spousal Coverage Parental Coverage	COBRA / Retiree Coverage Individual / Marketplace	VA Coverage / Tricare Medicare / Medicaid	Other____________

Do you or any of your dependent(s) have other coverage, including Medicare, that will remain in force while enrolled in any of these plans? Y / N

***If you answered "Yes" to either of the questions above, please provide detailed information in the box below.**

Additional Enrollment Information

You have been given an opportunity to participate in your employer's Group Insurance Plan and have indicated your choices above. Your signature indicates your understanding that these premiums will be deducted on a pre-taxed basis and cannot be changed during the plan year without evidence of a qualifying event. You understand that if you have refused coverage(s) above and request coverage at a later date, you may be required to furnish evidence of a qualifying event and must make that request within 30 days of such event. If you would like to opt out of the premiums being withheld pre-taxed, please see HR.

Date:______________

Employee Name:______________________________

Employee Signature:____________________________