

Urethane Roller Specialist Benefit Selection 2023

Medical - Aetna	Aetna AFA CPOSII 3500 80/50 ER CY V22 30015990 - Base Plan	Aetna AFA CPOSII 3000 100/50 ER CY V22 30015984 - Buy-up Plan
Lifetime Maximum	Unlimited	Unlimited
Deductible	Embedded	Embedded
Individual (In/Out Network)	\$3,500 / \$7,000	\$3,000 / \$6,000
Family (In/Out Network)	\$7,000 / \$14,000	\$6,000 / \$18,000
Co-Insurance (In/Out Network)	20% / 50%	0% / 50%
Max Out of Pocket		
Individual (In/Out Network)	\$6,500 / \$17,000	\$6,000 / \$16,000
Family (In/Out Network)	\$13,000 / \$51,000	\$12,000 / \$48,000
AD = After Deductible		
Preventive Office Visit	\$0	\$0
Dr.'s Office Visit	\$35 Primary Copay \$75 Specialist Copay	\$35 Primary Copay \$75 Specialist Copay
Emergency Room-Facility charge (Doc and other services may be subject to deductible and coinsurance)	\$300 Copay + Deductible + 20% Coinsurance	\$300 Copay + Deductible
Urgent Care-Facility charge (Doc and other services may be subject to deductible and coinsurance)	\$75 Copay	\$75 Copay
In Patient Hosp	20% Coinsurance AD	0% Coinsurance AD
Out Patient Svcs		
Diagnostic Labs (Not Major)		
Diagnostic X-Ray (Not Major)	20% Coinsurance AD	0% Coinsurance AD
Same Day Surgery		
Major Diagnostics		
Drug Card		
Tier 1-Non-Specialty/Specialty	\$3 / \$10 Copay	\$3 / \$10 Copay
Tier 2-Non-Specialty/Specialty	\$50 Copay	\$45 Copay
Tier 3-Non-Specialty/Specialty	\$80 Copay	\$75 Copay
Tier 4-Non-Specialty/Specialty	20% up to \$250 / 40% up to \$500	20% up to \$250 / 40% up to \$500
Medical Rates		
Per Pay Period Rates		
Weekly Rates - Per Pay Check	Base Plan	Buy-up Plan
Employee	\$0.00	\$12.01
Employee & Spouse	\$114.04	\$138.76
Employee & Child(ren)	\$100.36	\$123.55
Family	\$238.35	\$276.93
I wish to WAIVE Medical coverage		

Dental Benefit Summary	Principal
Preventive	100% / 100%
Basic	80% / 80%
Major	50% / 50%
Orthodontics	N/A
Deductible (Ind/Fam)	\$50 / \$150
Waived Preventive	\$1,000
Annual Maximum Benefit	\$1,000
Dental Rates	
Per Pay Period	
Check Election box	
Employee	\$0.00
Employee + Spouse	\$6.75
Employee + Child(ren)	\$9.16
Family	\$17.01
I wish to WAIVE Dental coverage	
Is this a Coverage Change?	
YES	NO

Voluntary Vision Summary	Principal
Exam	\$10
Lenses	\$25
Frequencies: Exam/Lenses/Frames	12/12/24
Frame Allowance	\$150
Contact Allowance	\$150
Voluntary Vision Rates	
Per Pay Period	
Check Election box	
Employee	\$1.90
Employee & Spouse	\$3.90
Employee & Child(ren)	\$4.12
Family	\$6.56
I wish to WAIVE Vision coverage	
Is this a Coverage Change?	
YES	NO

Principal Base & Voluntary Life and AD&D		
Employee Base Life	\$15,000	<input checked="" type="checkbox"/>
Employee Benefit Amount	\$	
Spouse Benefit Amount	\$	
Child(ren) Benefit Amount	\$	
I wish to WAIVE Voluntary Life & AD&D		

**Please refer to Summary of Benefits for complete benefit information.

Search for your Doctors in the Aetna Open Access Network - Aetna Choice POS II
Visit www.aetna.com. Click on "Find a doctor" and under "Guests" choose "Plan from an employer".

Under "Select a Plan" scroll down to the 3rd heading of "Aetna Open Access Plans".
Indicate the 1st option-Aetna Choice POS II (Open Access).

MEDICAL: Employees enrolling in the Aetna Medical Plan must complete both sides of this form and list any dependents also enrolling.

DENTAL & VISION: If enrolling for the first time or changing dependent elections, the reverse side of this form must be completed.

VOLUNTARY LIFE: If making any changes to the Voluntary Life election, please see Melonie for correct forms.

All forms are to be turned in to Melonie Johnson no later than Friday February 10, 2023. All changes will take effect on 3/1/2023.

You have been given an opportunity to participate in your employer's Group Insurance Plan and have indicated your choices on this form. Your signature indicates that you understand 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), and request coverage at a later date, other than at open enrollment, you may be required to furnish evidence of a qualifying event and must make that request within 30 days of such event.

VOLUNTARY LIFE & AD&D COVERAGE -

Employee may purchase 1 increment of \$10,000 annually up to \$300,000 max (Proof of good health required for amounts greater than \$70,000)

Spouse may purchase 1 increment of \$5,000 annual up to \$100,000 max (Proof of good health required for amounts greater than \$20,000)

Child(ren): Benefit amount = \$10,000 Guarantee Issue

Name: _____

Signature: _____

Date: _____

