UNIVERSITY PHYSICIAN ASSOCIATES OF NEW JERSEY, INC.

THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

# MEMORANDUM

To: UPA & DCMC Employees

From: Donna Sawler, Human Resources

Date: September 29, 2015

Re: Open Enrollment Meeting & Health and Dental Insurance Update

It is time for Open Enrollment for UPA/DCMC's Medical and Dental plans.

Medical (BCBS POS/Direct Access) – I am happy to announce, UPA/DCMC will continue to offer the two existing medical plans with few changes to the existing plan design. There will be an increase to the current payroll deduction; therefore, **it is mandatory for everyone to execute a new payroll deduction sheet (attached).**

Dental (Premier, Preferred & Flagship/DeltaCare) – I am happy to announce, UPA/DCMC will continue to offer the three existing dental plans without any change to the existing plan design. There will be no change in your payroll deduction!

**Should you have the desire to join, change from one plan to the other, or add or remove dependents, this is the time to do so and you must fill out a new enrollment form! If you ARE NOT CHANGING ANYTHING to your existing plan, you will only need to sign/date the payroll deduction sheet due to the increase.**

**Should you desire to join or have a change in plans, please RSVP by calling Extension 2-3672 NO LATER THAN MONDAY, OCTOBER 5, 2015 to attend one of the meetings listed below – lunch will be provided. It is important to bring your Social Security Number and the Social Security Number(s) of any dependent(s) you wish to enroll.**

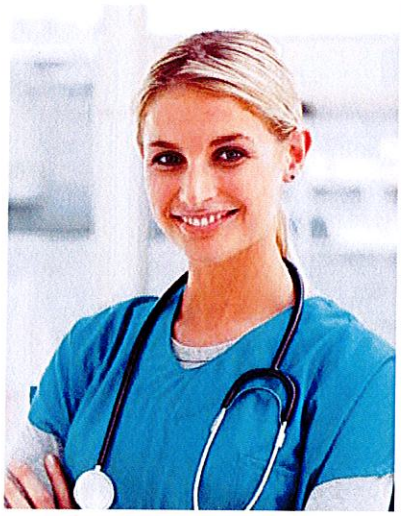
| | | |
|---|---|---|
| Tuesday, October 6, 2015 | **12:00 pm SHARP** to 1:00 pm | Dental School<br>B Level, Room 723 |
| Thursday, October 8, 2015 | **1:00 pm SHARP** to 2:00 pm | Dental School<br>B Level, Room 723 |

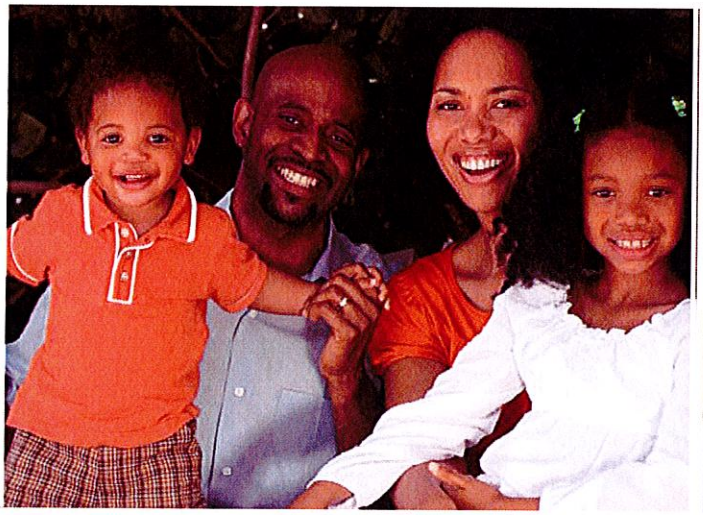
**If you choose to not participate in UPA's medical/dental plans, it is mandatory that you fill out the attached Waiver and a copy of your most recent insurance card. The completed Waiver and card copy should be sent to Human Resources, ADMC 12, Rm. 1201 no later than October 16, 2015. Upon receipt of the completed Waiver, you will be eligible to receive a quarterly payment for this benefit year. These quarterly payments will be taxable to you as compensation. The first check will be distributed, via UPA courier, January 15, 2016. If you do not complete and submit the Waiver, you will not be eligible for this benefit and will not receive payment.**

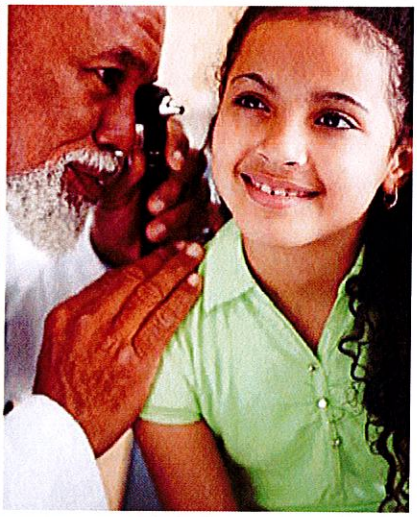
Thank you.

w/encl.
Waiver
BCBS Enrollment form
Delta Dental Enrollment form / payroll deduction form

30 Bergen Street, ADMC 12 1205 • Newark. NJ 07107 • Phone (973) 972-5004 • Fax: (972) 972-7069







2015-2016 EMPLOYEE BENEFITS GUIDE

# BENEFITS THAT BENEFIT YOU

UNIVERSITY PHYSICIAN ASSOCIATES OF NEW JERSEY, INC.

## OPEN ENROLLMENT EFFECTIVE NOVEMBER 1, 2015

UPA/DCMC takes pride in providing a comprehensive employee benefits program that continues to meet our employees' evolving needs and ensuring a level of security and protection. We also recognize the important role employee benefits play as a critical component of your overall compensation.

## MEDICAL/PRESCRIPTION

Your Medical/Prescription carrier will continue to be with Horizon BlueCross BlueShield of New Jersey with minor changes to the plan design. You will still have the option to choose between the POS and Direct Access plans. For both the POS and Direct Access plans there will be slight increase to your cost. Enclosed in this bulletin you will find a brief overview of the medical and prescription plans which will be effective November 1, 2015. Please refer to the Horizon medical and prescription benefit summaries for more details.

## DENTAL BENEFITS

Your Dental carrier will continue to be with Delta Dental with no changes to the plan designs. You will continue to have a choice between the Flagship/ DeltaCare Plan and the Premier or Preferred PPO Plans. There will be no increase to the cost of the Premier or Preferred PPO Plans. Enclosed in this bulletin you will find a brief overview of the dental plans which will be effective November 1, 2015. Please refer to the Delta Dental benefit summaries for more details.

# INSIDE

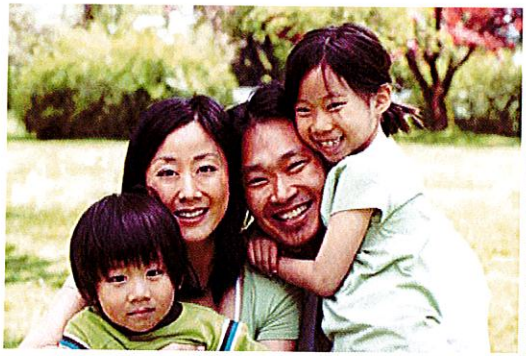
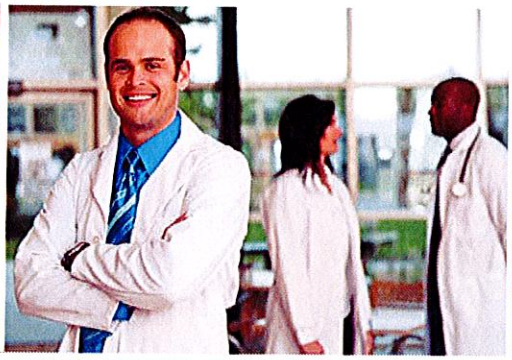
# 2015-2016 BENEFITS

## MEDICAL AND PRESCRIPTION PLAN

Horizon

Horizon Blue Cross Blue Shield of New Jersey

| BENEFIT | POS Design 4 | DA Design 5 |
|---|---|---|
| **IN-NETWORK BENEFITS** | **IN-NETWORK BENEFITS** | **IN-NETWORK BENEFITS** |
| PCP Election & Referral Required | Yes | No |
| In-Network Deductible | $500 Individual<br>$1,000 Family | None |
| In-Network Coinsurance | 90% | 100% |
| In-Network Out-of-Pocket Maximum<br>*(deductible, copays and coinsurance included)* | $2,000 Individual<br>$4,000 Family | $3,000 Individual<br>$6,000 Family |
| In-Network Lifetime Maximum | Unlimited | Unlimited |
| Primary Care Physician | **$25 copay** | **$25 copay** |
| Specialist | **$50 copay** | **$50 copay** |
| In-Network Hospital Care | 90% after deductible | 100% after $200 copay |
| Outpatient Surgery | 90% after Deductible | 100% |
| **OUT-OF-NETWORK BENEFITS** | **OUT-OF-NETWORK BENEFITS** | **OUT-OF-NETWORK BENEFITS** |
| Out-of-Network Deductible | $500 Individual<br>$1,000 Family | $1,000 Individual<br>$2,000 Family |
| Out-of-Network Coinsurance | 70% | 70% |
| Out-of-Network Out-of-Pocket Maximum<br>*(deductible included)* | $4,000 Individual<br>$10,000 Family | $3,000 Individual<br>$6,000 Family |
| Out-of-Network Lifetime Maximum | Unlimited | Unlimited |
| Primary Care Physician | 70% after deductible | 70% after deductible |
| Specialist | 70% after deductible | 70% after deductible |
| Out-of-Network Hospital Care | 70% after deductible | 70% after deductible and $200 copay |
| Outpatient Surgery | 70% after deductible | 70% after deductible |
| **EMERGENCY CARE** | **EMERGENCY CARE** | **EMERGENCY CARE** |
| Emergency Room | 90% after **$100 copay** | 100% after **$100 copay** |
| **PRESCRIPTION DRUG** | **PRESCRIPTION DRUG** | **PRESCRIPTION DRUG** |
| Retail Pharmacy (up to 30 days) | **$20 / $40 / $60** | **$20 / $40 / $60** |
| Mail Order (up to 90 days) | **$40 / $80 / $120** | **$40 / $80 / $120** |


# DENTAL PLAN

DELTA DENTAL®

## Flagship/DeltaCare Plan

## Delta Dental Premier & Preferred PPO*

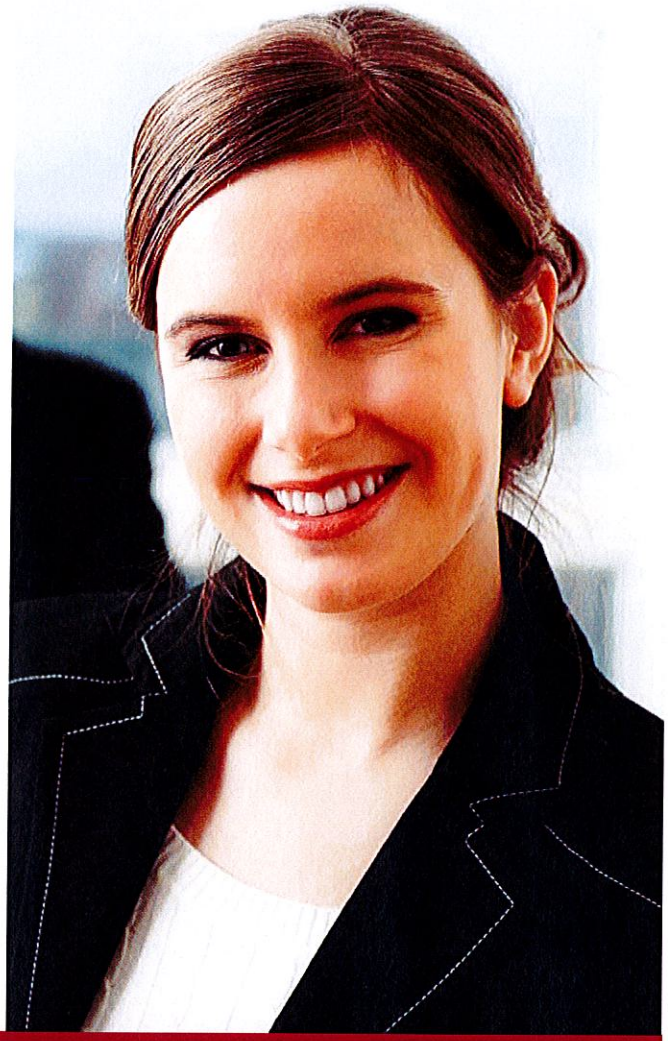
| BENEFIT | IN-NETWORK ONLY | PREMIER PPO | PREFERRED PPO |
|---|---|---|---|
| **Office Visit Co-pay** | $0 | $0 | $0 |
| **Annual Deductible** | None | $50 Individual<br>$150 Family | $50 Individual<br>$150 Family |
| **Calendar Year Maximum** | None | $1,500 Per Person | $1,500 Per Person |
| **Preventive Services** | No Cost<br>($20 copay Sealant - per tooth) | Covered 100% (deductible waived) | Covered 100% (deductible waived) |
| **Basic Services** | Please see Patient Charge Schedule<br>Various Copays Apply | Covered 80% (after deductible) | Covered 80% (after deductible) |
| **Major Services** | Please see Patient Charge Schedule<br>Various Copays Apply | Covered 50% (after deductible) | Covered 50% (after deductible) |
| **Orthodontic Services** | $2,600 copay (24 month treatment) | Covered 50% (deductible waived) | Covered 50% (deductible waived) |
| **Orthodontic Services**<br>(lifetime plan maximum) | N/A | $1,000 | $1,000 |

***Delta Dental Premier & Preferred PPO** allows employees the freedom to select the dentist of their choice. Employees receive the same benefits with either the Premier or PPO network or out-of-network dentists, but may experience higher cost sharing with out-of-network providers. Participating dentists have agreed to a lesser reimbursement from Delta Dental, thereby lowering a member's coinsurance and increasing the value of your annual maximum. Out of network dentists charge employees the difference between their fee for service and Delta's Reasonable & Customary (R&C) fees. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the subscriber. **To locate a participating dentist call 1-800-DELTA-OK and a list of participating dentists located in your area will be mailed directly to your home or got to Delta Dental's website at www.deltadentalnj.com.**

**Carryover Max℠** from Delta Dental allows you to increase your benefits. This valuable benefit feature allows you to carry over a portion of your unused standard annual maximum benefit limit into the next year, and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for larger, more expensive procedures in the future - such as bridges, crowns, and root canals. Please refer to your Delta Dental plan documents for more information on how to take advantage of this benefit.

# BenefitsVIP®

## ONE CALL DOES IT ALL!



BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members with:

- Benefits questions
- ID card issues
- Billing issues and claims resolution
- Prescription issues
- Provider network questions
- ...and much more!

## THE INSURANCE BEHIND YOUR INSURANCE

For personal service that's confidential and responsive, contact:

**1.866.293.9736**

Monday - Friday, 8:30am - 8:00pm (EST)
Fax: 1.856.996.2775

Solutions@benefitsvip.com

**BenefitsVIP** can resolve claims issues through carriers and service providers **3-4 times faster** than employees.

— Corporate Synergies BenefitsVIP Client Satisfaction Report

**Completely confidential!** A majority of issues are resolved the same day; and all calls adhere to privacy best practices.



This benefit summary provides selected highlights of the employee benefits program at University Physician Associates of NJ, Inc. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at University Physician Associates of NJ, Inc. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. University Physician Associates of NJ, Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

CORPORATE SYNERGIES®

UNIVERSITY PHYSICIAN
ASSOCIATES OF NEW JERSEY, INC.

THE FACULTY PRACTICE PLAN OF NEW JERSEY MEDICAL SCHOOL

# WAIVER

EMPLOYER HEALTH BENEFITS COVERAGE

## *MEDICAL:*

Employee Name_____

Policy Holder Name_____

Group Policy No._____

Marital Status: Single___ Married___ Widowed___ Divorced___

***I have been given the opportunity to enroll in University Physician Associates/Doctor's Center Management Corporation's group health plan. I refuse the following:***

___Employee, Spouse and Child coverage
___Spouse Coverage
___Child Coverage

Reason for refusal (Please check all appropriate boxes)
___other group coverage sponsored by spouse's employer
___other group coverage sponsored by another organization
___other reason (please explain)

_____

CARRIER NAME: _____
POLICY NUMBER:_____

## DENTAL:

____**I am also choosing to waive Dental Coverage**

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

Employee Signature_____ Date_____
Witness Signature_____ Date_____

30 Bergen Street, ADMC 12 1205 • Newark, NJ 07107 • Phone: (973) 972-5004 • Fax: (973) 972-7069

Horizon

Horizon Blue Cross Blue Shield of New Jersey

# GROUP ENROLLMENT/CHANGE REQUEST

Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Fax (973) 274-2297
www.HorizonBlue.com

## Group Information – to be completed by Employer.

Group Name: _____ Group Number: _____

Sub Group Number: _____

Date of Hire: ____/____/____ Effective Date/Date of Event: ____/____/____

Reason: _____

## A. Type of Activity – to be completed by Employer.

*Refer to instructions before completing this form. Print clearly.*

☐ **ADD** ☐ **REMOVE** ☐ **OTHER CHANGE**

| | Effective Date/Date of Event | Reason for Change |
|---|---|---|
| ☐ Subscriber | ____/____/____ | |
| ☐ Spouse | ____/____/____ | |
| ☐ Civil Union Partner (CUP) | ____/____/____ | |
| ☐ Domestic Partner (DP) | ____/____/____ | |
| ☐ Dependent Child | ____/____/____ | |
| ☐ Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)* | ____/____/____ | |
| ☐ Name Change | ____/____/____ | |
| ☐ Change Plan | ____/____/____ | |
| ☐ Other | ____/____/____ | |
| ☐ Add/Change Office ID Numbers: Primary Care Provider | ____/____/____ | |

**COVERAGE CONTINUATION**

☐ **For Employee** Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29

**Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner** Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36 Billing: ☒ Group

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

☐ Dependent Under 31 Billing: ☒ Home

Date of Loss of Coverage ____/____/____ Qualifying Event #** _____ Date of Qualifying Event ____/____/____

Home Address: _____

***Qualifying event #s: see list in Instructions.*

## B. Employee Information – to be completed by Employee.

☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

*If a name change, indicate prior name:* _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth ____/____/____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name _____ Employment Date ____/____/____

Hours Worked
Employer Address _____ City _____ State _____ Zip Code _____

Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

## C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin
☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

## D. Plan Option – to be completed by the Employee. Your selection must be offered by your employer.

**Medical** *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Traditional ☐ Horizon PPO (HRA) ☐ Horizon Advantage EPO
☐ Horizon HMO ☐ Horizon PPO (HSA) ☐ Horizon Advantage EPO (HRA)
☐ Horizon POS ☐ Horizon Direct Access (HRA) ☐ Horizon Advantage EPO (HSA)
☐ Horizon PPO ☐ Horizon Direct Access (HSA)
☐ Horizon Direct Access ☐ Horizon EPO

**Dental** *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Dental Option Plan ☐ Horizon Dental PPO Plan ☐ Horizon Dental PPO Access

**Vision** *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

☐ Horizon Vista I ☐ Horizon Panorama III - ALT. B ☐ Horizon Expanse V
☐ Horizon Vista II ☐ Horizon Panorama IV - ALT. A ☐ Horizon Expanse VI
☐ Horizon Panorama III - ALT. A ☐ Horizon Panorama IV - ALT. B

**Prescription** *Check One:* ☐ S ☐ F ☐ 2 Adults ☐ PC

S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union Partners or Domestic Partners; P/C = Parent/Child(ren)

*The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.*

## E. Other Individuals Covered – to be completed by Employee.

*Identify individuals other than yourself for whom you are adding/changing/removing/ continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.*

**1. SPOUSE/CUP/DP** ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)**
☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (COBRA/NJSGC)** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section F2*

**2. Child** ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

**3. Child** ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth ____/____/____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

## F. Additional Spouse/CUP/DP Information – to be completed by Employee.

*If not applicable mark as N/A.*

1. Employer Name _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

2a. Home Address _____ Apt _____

City _____ State _____ Zip Code _____

2b. Please explain why the address is different: _____

## G. Additional Child Information – to be completed by Employee.

*Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

## H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: ___/___/___

## I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: ___/___/___

## J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: ___/___/___

Representative's Title: _____

# DENTAL ENROLLMENT FORM

**Eight Digit Group Number**

☐ Delta Dental Premier® _____ - _____

☐ Delta Dental Premier®/Advantage Program _____ - _____

☐ Delta Dental PPO℠ plus Premier Program _____ - _____

☐ Delta Dental PPO℠ _____ - 6_____

☐ Advantage Program _____ - 8_____

☐ DeltaCare® _____ - 9_____

| Name of Employer | Effective Date of Coverage |
|---|---|
| | |

## GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

| Name (Last) (First) (Middle) | Date of Birth | Social Security Number |
|---|---|---|
| | _____/_____/_____ | ___ ___ ___ - ___ ___ - ___ ___ ___ ___ |

| Street Address | City, State, Zip | County |
|---|---|---|
| | | |

| Date of Employment | Type of Coverage | Marital Status | Home Telephone |
|---|---|---|---|
| _____/_____/_____ | ☐ Single ☐ Parent/Child<br>☐ Husband/Wife ☐ Parent/Children<br>☐ Family | ☐Single<br>☐Married<br>☐Divorced/Separated | ( ) |

| Enrollment | First Name - Last Name | Social Security Number | Date of Birth | Full-Time Student |
|---|---|---|---|---|
| Subscriber | | _____ - _____ - _____ | / / | |
| Spouse* | | _____ - _____ - _____ | / / | |
| Dependent | | _____ - _____ - _____ | / / | ☐ Yes ☐ No |
| Dependent | | _____ - _____ - _____ | / / | ☐Yes ☐No |
| Dependent | | _____ - _____ - _____ | / / | ☐Yes ☐No |
| Dependent | | _____ - _____ - _____ | / / | ☐Yes ☐No |

* If spouse has other dental coverage, please list name and address of employer and other carrier:

## If choosing DeltaCare, you must complete this section

| | Choice of Dentist | Office Number | For Delta Use Only |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

_____ _____

Subscriber Signature Date

Delta Use Only

_____

Entered

_____

Operator #

# 2015
# Bi-Weekly Contributions

The rates below represent your bi-weekly contributions towards the overall cost of employee health benefits offered by University Physician Associates of New Jersey Inc.

In order to participate in the Horizon Blue Cross/Blue Shield Direct Access Plan, I authorize UPA/DCMC to withhold an amount of money from each paycheck based upon the following salary schedule:

## Horizon Open Access POS

| Salary Range | Single | Husband & Wife | Parent & Child | Family |
|---|---|---|---|---|
| Under - $20,000 | ☐ $16.00 | ☐ $32.07 | ☐ $26.74 | ☐ $53.37 |
| $20,000 - $29,999 | ☐ $19.99 | ☐ $40.01 | ☐ $29.33 | ☐ $58.70 |
| $30,000 - $49,999 | ☐ $22.01 | ☐ $43.63 | ☐ $32.03 | ☐ $64.04 |
| $50,000 - $74,999 | ☐ 24.00 | ☐ $48.03 | ☐ $34.63 | ☐ $69.42 |
| $75,000 - Over | ☐ $26.01 | ☐ $52.00 | ☐ $37.33 | ☐ $77.16 |

## Horizon Direct Access Buy Up

| Salary Range | Single | Husband & Wife | Parent & Child | Family |
|---|---|---|---|---|
| Under - $20,000 | ☐ $82.62 | ☐ $162.69 | ☐ $128.79 | ☐ $228.99 |
| $20,000 - $29,999 | ☐ $86.24 | ☐ $169.90 | ☐ $131.14 | ☐ $233.82 |
| $30,000 - $49,999 | ☐ $88.08 | ☐ $173.18 | ☐ $133.60 | ☐ $238.65 |
| $50,000 - $74,999 | ☐ $89.86 | ☐ $177.17 | ☐ $135.96 | ☐ $243.57 |
| $75,000 - Over | ☐ $91.70 | ☐ $180.78 | ☐ $138.42 | ☐ $250.59 |

## Dental

| | Flagship/DeltaCare Plan | Delta Dental Preferred Plan | Delta Dental Premier Plan |
|---|---|---|---|
| Bi Weekly Cost | ☐ $7.00 | ☐ $6.00 | ☐ $10.00 |

**Employee Name**

**Employee Signature**

**Date**

CORPORATE SYNERGIES®