TC Hafford Basement Systems

Leaks • Cracks • Humidity • Crawl Spaces

TC HAFFORD WATERPROOFING, INC.
BENEFIT ELECTION FORM
Effective 7/1/2024

Please complete and return this form to Human Resources regardless of whether selecting or waiving coverage

Harvard Pilgrim Health Care	POS 5000 MD 22134	ME Choice Plus HMO 4000 MD 22227		HMO HSA MD 19110
EFFECTIVE DATE	7/1/2024	7/1/2024		7/1/2024
NETWORK		*PREFERRED*	*STANDARD*	
DEDUCTIBLE (Single / Family)	$5,000 / $10,00 (IN) $10,000/ $20,000 (OUT)	$4,000 / $8,000	$6,000 / $12,000	$4,000 / $8,000
COINSURANCE	30% (IN) 50% (OUT)	20%	40%	20% (IN) N/A
TOTAL OUT OF POCKET (Single / Family)	$7,500 / $15,000 (IN) $14,750 / $29,500 (OUT)	$6,000 / $12,000	$7,350 / $14,700	$6,000 / $12,000
INPATIENT HOSPITAL SERVICES	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE		DEDUCTIBLE & COINSURANCE
OUTPATIENT DAY SURGERY	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE		DEDUCTIBLE & COINSURANCE
PROFESSIONAL FACILITY CHARGES	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE		DEDUCTIBLE & COINSURANCE
PRIMARY CARE VISIT	$25 (IN)	$35	$50	DEDUCTIBLE & COINSURANCE
SPECIALIST VISIT	$45 (IN)	$35	$50	DEDUCTIBLE & COINSURANCE
CHIROPRACTIC SERVICES	$25 (IN)	$35		DEDUCTIBLE & COINSURANCE
ROUTINE PHYSICAL EXAM	$0 (IN)	$0	$0	$0
ANNUAL GYN VISIT	$0 (IN)	$0	N/A	$0
ROUTINE EYE EXAM	$25 (IN)	$35	$50	$0 DED & COINS
MRI/CAT/PET SCAN	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE		DEDUCTIBLE & COINSURANCE
DIAGNOSTIC TESTING	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE		DEDUCTIBLE & COINSURANCE
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY (60 VISITS/YR.)	$45 COPAY (60 visits/year)	$50 COPAY Preferred; DED & COINS Standard (60 VISITS/YR)		DED & COINS (60 VISITS/YR)
AMBULANCE	30% COINSURANCE	20% COINSURANCE		PREFERRED DED, THEN 30% COINS
URGENT CARE SERVICES (Retail Heath Clinic / Hospital Clinic)	$25 (IN)	$35 / $50	$50/DED & COINS	DEDUCTIBLE & COINSURANCE
EMERGENCY ROOM	DEDUCTIBLE & COINSURANCE	$300		DEDUCTIBLE & COINSURANCE
DRUG CARD (30 DAY SUPPLY) (Pref. Generic/ Non-Pref. Generic/ Pref. Brand/ Non-Pref. Brand & Pref. Specialty/ Non-Pref. Specialty)	$5/ $25/ $50/ 30% to $250 per script max/ 30% to $250 per script max	$5/ $25/ $50/ 30% to $250 per script max/ 30% to $250 per script max		DEDUCTIBLE**, then $5/ $25/ $50/ 30% to $250 per script max/ 30% to $250 per script max
MAIL ORDER DRUGS (90 DAY SUPPLY)	2 COPAYS, Tier 4 to $500, Tier 5 to $500	2 COPAYS, Tier 4 to $500, Tier 5 to $500		DEDUCTIBLE**, then 2 COPAYS, Tier 4 to $500, Tier 5 to $500
PREVENTIVE RX	N/A	N/A		Deductible Waived

MEDICAL EMPLOYEE DEDUCTIONS PER PAY PERIOD (WEEKLY)			
EMPLOYEE	$84.20	$73.07	$39.01
EMPLOYEE & SPOUSE	$197.47	$182.99	$170.59
EMPLOYEE & CHILD(REN)	$182.66	$169.27	$157.80
FAMILY	$306.07	$283.64	$264.42

DENTAL EMPLOYEE DEDUCTIONS PER PAY PERIOD (WEEKLY)		**VISION EMPLOYEE DEDUCTIONS PER PAY PERIOD (WEEKLY)**	
EMPLOYEE	$7.70	EMPLOYEE	$1.93
EMPLOYEE & 1 DEPENDENT	$16.09	EMPLOYEE & 1 DEPENDENT	$3.24
EMPLOYEE & 2 OR MORE	$27.97	EMPLOYEE & 2 OR MORE	$5.25

ADDITIONAL HSA FUNDING: If enrolled in the HSA plan, see back side to indicate any amount you would like deducted from your paycheck per pay period to fund your Health Savings Account.

*This is a summary only. Please refer to Benefit Summaries for further details & any limitations on benefits. Plan documents govern.

JULY 1, 2024 MEDICAL, DENTAL & VISION PLAN OPTIONS

Check the box next to the plan you would like to select:

TC Hafford Basement Systems
Leaks • Cracks • Humidity • Crawl Spaces

MEDICAL PLAN OPTIONS	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
POS 5000				
ME Choice Plus HMO 4000				
HMO HSA 4000				

*__If selecting the HSA plan:__ Please indicate amount here if you would like an additional amount deducted per pay period from your paycheck to fund your Health Savings Account: $_____

DENTAL & VISION PLAN OPTIONS	Employee Only	Employee & 1 Dependent	Employee & 2 or More Dependents
Harvard Pilgrim Point32Health DENTAL			
Harvard Pilgrim Point32Health-VISION			

Election Agreement: I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or my spouse's death; a change in the number of my federal tax dependents due to birth, adoption, placement for adoption, or death; a change in employment status for me, my spouse or federal tax dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes my federal tax dependent to satisfy or cease to satisfy status as a dependent; a change in my, my spouse's or my dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events is defined in the Summary Plan Description and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a non-flexible spending account benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

_____

Signature Date

—OR—

Waiver of election: I have reviewed the Group Medical, Dental & Vision offers and at this time, I am waiving my right to election. If you refuse coverage for yourself then you automatically refuse coverage for your dependents. If you refuse coverage now, and later request to add that benefit, entry restrictions may apply.

MEDICAL ☐ Reason for Waiver: _____ DENTAL ☐ VISION ☐

_____

Signature Date

All Employees Complete:

_____

Name

_____

Address