Employee Election Form

February 1, 2020 - January 31, 2021

Employee Name:

Medical — BlueCross BlueShield of Tennessee

	Option 1 - Silver 70 HDHP	Option 2 - Silver 87	Option 2 - Silver 85
Network	Blue Network S	Blue Network S	Blue Network S
Deductible	$3600 (2 per Family)	$6500 (2 per Family)	$3000 (2 per Family)
Coinsurance	50% after Deductible	50% after Deductible	70% after Deductible
Out of Pocket Max	$6650 (2 per Family)	$8000 (2 per Family)	$6300 (2 per Family)
Primary Care Visit	Subject to Deductible / Coinsurance	$35 Copay	Subject to Deductible / Coinsurance
Specialist Visit	Subject to Deductible / Coinsurance	$75 Copay	Subject to Deductible / Coinsurance
Physician Now	Subject to Deductible / Coinsurance	$10 Copay	$10 Copay
Wellcare	Paid @ 100%	Paid @ 100%	Paid @ 100%
ER / Urgent Care	Subject to Deductible / Coinsurance	ER: Ded/Coins UC: $75 Copay	Subject to Deductible / Coinsurance
Pediatric Dental & Vision	Included to Age 19	Included to Age 19	Included to Age 19
Pharmacy	Subject to Deductible / Coinsurance	$10 / $75 / $150	$10 / $45 / $90
Preventive Rx	$10 / $35 / $60	N/A	N/A
Cost per Pay Period (52)			
Employee Only	☐ $51.95	☐ $68.81	☐ $71.36
Employee/Spouse	☐ $115.45	☐ $149.16	☐ $154.26
Employee/Child(ren)	☐ $105.92	☐ $137.11	☐ $141.82
Family	☐ $169.42	☐ $217.46	☐ $224.72
☐ DECLINE MEDICAL COVERAGE			

Dental — BlueCross BlueShield of Tennessee

Preventive Services	Covered @ 100%
Basic Services	Covered @ 80% after Deductible
Major Services	Covered @ 50% after Deductible
Orthodontics	Not Covered
Deductible	$50 (3 per Family)
Annual Maximum	$2000 per Covered Person
Cost per Pay Period (52)	
Employee Only	☐ $6.96
Employee/Spouse	☐ $13.92
Employee/Child(ren)	☐ $13.05
Family	☐ $19.33
☐ DECLINE DENTAL COVERAGE	

Vision — BlueCross BlueShield of Tennessee

Eye Examination	$10 Copay
Lenses	$25 Copay
Frames	$150 Allowance
Contacts (in lieu of glasses)	$150 Allowance
Frequency	12 months Exam/Lenses, 24 months for Frames
Cost per Pay Period (52)	
Employee Only	☐ $1.61
Employee/Spouse	☐ $3.22
Employee/Child(ren)	☐ $3.62
Family	☐ $5.01
☐ DECLINE VISION COVERAGE	

ZINNIA wellness

Benefits, inc.

Employee Benefits Summary

February 1, 2020 - January 31, 2021

Enrollment Information

Employee Last Name	First Name	SSN	Date of Birth	Gender
				☐ M ☐ F

Address	City, State	Zip Code

Dependent Information

Spouse Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 1 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 2 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 3 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Child 4 Last Name	First Name	SSN	DOB	Gender
				☐ M ☐ F

Section 125 Agreement

I cannot change or revoke this Benefit Election Agreement before the beginning of the next Plan Year unless a change in status occurs. For this purpose, a change in status includes:

MARRIAGE / DIVORCE

ADDITION / LOSS OF A DEPENDENT

TERMINATION / COMMENCEMENT OF EMPLOYMENT

TAKING AN UNPAID LEAVE OF ABSENCE

Further, I understand that any requested change must be on account of and consistent with the change in status and that the change must be requested within 30 days of the recognized event.

My execution of this Benefit Election Agreement does not begin coverage under any benefit or insurance policy. The terms and conditions of the underlying benefit plan or insurance policy with determine my entitlement to benefits thereunder.

Prior to the beginning of each plan year, I may be offered the opportunity to change my benefit election(s) for the following plan year. If I fail to submit a Benefit Election Agreement at that time, I will continue any coverages for the new plan year, and I will continue to have the appropriate amounts withheld from my salary for my coverage.

The Company and I hereby agree that my cash compensation will be reduced by the amounts set forth for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement.)

Employee Signature **Date**