Alternative Correctional Healthcare
2025 BENEFIT ELECTION FORM (Effective 7/1/2025)

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

	Community Health Options	
	OPTION #1	**OPTION #2**
	Clear Choice Silver 3500 HMO Tiered NE	**Clear Choice Bronze 7500 HMO Tiered NE**
DEDUCTIBLE		
IN NETWORK Single/Family	Tier 1: $3,500/$7,000	Tier 1: $7,500/$15,000
	Tier 2: $4,200/$8,400	Tier 2: $9,00/$18,000
TOTAL OUT OF POCKET		
IN NETWORK Single/Family	$8,500/$17,000	$9,200/$18,400
COINSURANCE		
IN NETWORK	Tier 1: 30% / Tier 2: 50%	Tier 1: 50% / Tier 2: 60%
PHYSICIAN OFFICE VISIT		
PRIMARY CARE VISIT ($0 1st Visit Non-Prev)	Tier 1: $40 / Tier 2: $70 (PCP Required)	Tier 1: $45 / Tier 2: $80 (PCP Required)
SPECIALIST VISIT	Tier 1: $60 / Tier 2: DED, then $60	Tier 1: $80 / Tier 2: DED, then $80
PREVENTIVE CARE (Routine Annual Physical & Gyn Exam)	COVERED IN FULL (IN)	COVERED IN FULL (IN)
COVERED SERVICES		
DIAGNOSTIC TESTING	DED + COINS	DED + COINS
IMAGING (MRI/CAT/PET SCAN)	DED + COINS	DED + COINS
OUTPATIENT SURGERY	DED + COINS	DED + COINS
EMERGENCY ROOM	DED + COINS	DED + COINS
INPATIENT HOSPITAL	DED + COINS	DED + COINS
PHYSICAL, SPEECH & OCC.THERAPY	Tier 1: $40 / Tier 2: $140 (60 visits/yr)	Tier 1: $45 / Tier 2: $145 (60 visits/yr)
URGENT CARE	$40	$60
PRESCRIPTION DRUGS		
RX DEDUCTIBLE	N/A	N/A
TIER 1 / TIER 2 / TIER 3 / TIER 4 / TIER 5	$5/$25/$50/DED then $100/DED then $250	$5/$30/ DED then $50/DED then $100/DED then $250
90 DAY SUPPLY - MAIL ORDER	2 COPAYS (Tier 1-3); DED then 2 COPAYS	2 COPAYS (Tier 1-2); DED then 2 COPAYS

BI-WEEKLY MEDICAL RATES		
EMPLOYEE	$137.08	$115.93
EMPLOYEE + SPOUSE	$274.15	$231.87
EMPLOYEE + CHILD(REN)	$253.59	$214.48
FAMILY	$424.94	$359.40

BI-WEEKLY DENTAL RATES	
EMPLOYEE	$13.72
EMPLOYEE + SPOUSE	$24.46
EMPLOYEE + CHILD(REN)	$26.42
FAMILY	$43.26

BI-WEEKLY VISION RATES	
EMPLOYEE	$1.30
EMPLOYEE + SPOUSE	$2.53
EMPLOYEE + CHILD(REN)	$2.46
FAMILY	$3.81

Employee Name

Alternative Correctional Healthcare
July 1, 2025

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

MEDICAL, DENTAL & VISION ELECTIONS

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
MEDICAL: Silver 3500 HMO				
MEDICAL: Bronze 7500 HMO				

	PCP Name	City
Please Insert PCP Information		

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
DENTAL PLAN				
VISION PLAN				

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 pre-tax elections will remain in effect until the end of the plan year unless I have a qualifying event. 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 Insurance Plan 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. Please check applicable box if waiving coverage.

MEDICAL ☐ DENTAL ☐ VISION ☐

Signature Date

ALL EMPLOYEES COMPLETE:

Signature **Date**

Name

Address

City **State** **Zip**