2018/2019 FLEXIBLE BENEFITS ENROLLMENT FORM for FULL-TIME EMPLOYEES

ASEA Health Trust

Please see the 2018/2019 Health Benefits Open Enrollment Guide for more information about your benefits.

Member name: Health Plan ID:

1. CHOOSE YOUR HEALTH PLAN—Choose one (Refer to the chart on page 3 to compare Plans)

❑ **Plan A: Full Plan for Employees and Families** (the default Plan if you do not enroll) **$295 monthly employee contribution**

❑ **Plan B: Full Plan for Employees Only** **$140 monthly employee contribution**
You may choose Plan B only if you are single or all of your eligible family members have other health coverage (list in Section 4 below)

❑ **Plan C: Supplemental Plan for Employees and Families** **$35 monthly employee contribution**
You may choose Plan C only if you and all of your eligible family members have other health coverage (list in Section 4 below)

❑ **Plan D: Low Option Plan for Employees and Families** **$40 monthly employee contribution**

***Before* you enroll for Plan C (or Plan B, if you are married or have dependent children)** call your other health plan to understand how it will work with the ASEA Health Plan (some plans, including Alaska Care, may limit coverage). **Regardless you must still enroll by the deadline!**

2. HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)—Choose one

❑ **Yes**, enroll me in a HCRA for 2018/2019 Plan Year, from which I will be reimbursed for eligible health care expenses that I incur.
(I understand that my monthly employee Health Plan contribution is NOT eligible for HCRA reimbursement.)
Deduct $_____.00 (min. $20, max. $220.83) per month from my paycheck for my monthly HCRA contribution.
❑ Check here to authorize the Health Trust to automatically submit the unpaid portion of your health claims to your HCRA (available only if you do not have other health coverage).

❑ **No**, I do not want to participate in the Health Care Reimbursement Account (HCRA).

3. SPOUSE EMPLOYMENT (MUST BE COMPLETED IF YOU ARE ENROLLING YOUR SPOUSE)

Please check one of the following:

a. Is your spouse currently employed? ❑ Yes ❑ No If no, go to Section 4

b. Is your spouse eligible* for health benefits through his or her employer? ❑ Yes ❑ No If no, go to Section 4
*Your spouse is considered eligible if his or her job position entitles them to be offered health benefits, even if your spouse declined coverage or failed to enroll timely.

c. Is your spouse enrolled in health benefits through his or her employer? ❑ Yes ❑ No*
*If your spouse is eligible for health coverage through his/her employer but did not enroll in that coverage, **a $125 per month surcharge will be added to your payroll deduction.**

4. OTHER HEALTH CARE COVERAGE—Choose one (Use additional paper if needed)

❑ **I do NOT have other health care coverage for myself, my spouse or my other dependents.**

❑ **I DO have other health care coverage (including Indian Health Services, Denali Kids, Medicare or Medicaid) for myself, my spouse or my other dependents** (provide information below):

Policyholder: Policyholder's date of birth:

Policy number: Effective Date: Type of plan: ❑ Active ❑ Retiree

Employer: Insurance Co.:

Insurance Co. phone: Address:

Coverage provided: ❑ Medical ❑ Dental ❑ Vision ❑ Prescription

Please list all family members (including you) enrolled in this health coverage:

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5. CONFIRMATION—Sign below to indicate you have read and understand:

I select the benefits as indicated above for the July 1, 2018–June 30, 2019 Plan Year:

I understand that I may not make midyear benefit changes unless I have a Qualifying Event in my family:

- Marriage
- Birth or adoption of a child
- Divorce or legal separation
- Death of a dependent
- Dependent ceasing to be eligible or gaining eligibility
- Loss, gain or significant change in other health coverage (HCRA selections may not be changed following a change in other coverage)
- Changing from full-time to permanent part-time status or vice versa

If I have a Qualifying Event, **including loss of other health coverage**, I must notify the Trust Office and submit proof of the event and a new Benefits Enrollment Form **within 60 days**. Changes become effective the first day of the month after the Trust Office receives my submissions (or, for newborns or newly adopted children, retroactive to the date of birth or adoption).

I further understand that failure to disclose my spouse's eligibility and enrollment in employer-sponsored health care coverage (Section 3) could result in the **retroactive assessment of the $125/month surcharge on a post-tax basis**.

By signing below, I certify all information provided on this form is true and correct.

Member Signature: **Date:**

6. ENROLL

- ENROLL ONLINE at www.aseahealth.org (click Online Enrollment) or securely by attaching it to a message through Contact Us.
- Or, FAX this completed form to the Health Trust Administrator at 1-509-323-7614
- Or, MAIL this form to: ASEA/AFSCME Local 52 Health Benefits Trust, 111 W. Cataldo, Suite 220, Spokane, WA 99201

2018/2019 HEALTH PLAN BENEFIT MAP for FULL-TIME EMPLOYEES

The chart below helps you compare the features and benefits of the different Plans—and choose which one is best for you.

Benefit	PLAN A Full Plan for Employee(s) and Families	PLAN B Full Plan for Employee(s) Only	PLAN C Supplemental Plan for Employee(s) and Families with Other Coverage	PLAN D Low Option Plan with $1,000 HRA for Employee(s) and Families
2018/2019 Monthly Full-Time Employee Contribution	$295	$140	$35	$40
MEDICAL				
Annual Deductible	$300/Individual $600/Family	$300	None	$5,000/Individual $10,000/Family
Plan Pays*	80% (60% of contracted price for non-PPO services)	80% (60% of contracted price for non-PPO services)	20%	100% (80% of contracted price for non-PPO services)
Out-of-Pocket Limit (not including deductible)**	$1,200/Individual ($2,400/ Individual for non-PPO services)	$1,200 ($2,400 for non-PPO services)	None	None
Preventive Care Services recommended under the ACA	100% (80% non-PPO**); not subject to deductible	100% (80% non-PPO**); not subject to deductible	100%; not subject to deductible	100% (80% non-PPO**); not subject to deductible
All Other Preventive Care	80% (60% non-PPO**)	80% (60% non-PPO**)	20%	80% (60% non-PPO**)
Prescription Drugs	Member copays: 20% brand name, 10% generic up to $60 per Rx*** $600 copay max per person per Plan Year	Member copays: 20% brand name, 10% generic up to $60 per Rx*** $600 copay max per person per Plan Year	Plan pays 20%; Member pays 80%***	Under the Medical Plan: Plan pays 100% after deductible
Major Medical Maximum	Unlimited	Unlimited	Unlimited	Unlimited
DENTAL				
Annual Deductible	$25/Individual $75/Family	$25	$25/Individual $75/Family	Not Covered
Plan Pays*	Preventive: 100% General: 85% Major: 50%			Not Covered
Individual Maximum	$2,000/Plan Year			Not Covered
VISION	**VSP In-Network**		**Out-of-Network**	
Plan Pays*	• Exam: Covered in full • Basic Lenses: Covered in full • Polycarbonate lenses and UV coating: Covered in full • One of the following covered in full: progressive or photochromic lenses or anti-reflective coating • Frames: $150 retail allowance with wholesale price guarantee (can be purchased on-line) • Contacts: $200 allowance and contact lens exam covered in full after $60 copay		• Exam: $150, every Plan Year • Lenses: $175, every Plan Year • Frames: $150, every other Plan Year • Contacts: $200, every Plan Year, in lieu of lenses and frames	Not Covered

*Plan payment is based on the Plan's Allowable Expenses. **Non-PPO out-of-pocket provisions apply to inpatient and outpatient services obtained at a non-preferred hospital or performed at a non-preferred physical therapist provided in the Municipality of Anchorage. ***For non-network pharmacies, you are responsible for the difference between the retail price at the pharmacy and the network reimbursement rate.

The Plan covers oral pediatric and vision services to the extent covered by the Affordable Care Act (ACA).