Pelham School District | **PEA Special Open Enrollment Election Coverage Form** | **9/1/2024 to 6/30/2025**

Employee Name : _____ EE #: _____ **Group: PEA 1.0**

Medical (Please select one below)

ACCESS BLUE, HMO / $20 Copay (AB20)		Rate	Annual
Single		$ 95.45	$ 1,908.83
2 Person		$ 190.89	$ 3,817.67
Family		$ 257.70	$ 5,153.85

ACCESS BLUE SITE OF SERVICE WITH DED (ABSOS1K)		Rate	Annual
Single		$ -	$ -
2 Person		$ -	$ -
Family		$ -	$ -

Waive *		No Medical Coverage

Dental (Please select one below)

DELTA DENTAL / Option 1S		Rate	Annual
Single		$ -	$ -
2 Person		$ 11.97	$ 239.38
Family		$ 21.41	$ 428.18

Waive		No Dental Coverage

Health/dental insurance premiums are deducted in 20 installments beginning with the first check of the school year. In June, an adjustment deduction may/will be made for premium rate changes for the months of July and August. Open Enrollment occurs each year in the month of May for a July 1st effective date. Should a qualifying event occur during the year, such as loss of a spouse's coverage, marriage, birth or divorce, an enrollment form will need to be completed and submitted within 30 days of the event for processing. Payroll deductions will then be modified in accordance with the change.

* In accordance with Article XI, C of the PEA Agreement, a medical buyout amount of $3,000 (prorated based upon FTE) is available to those who meet the requirements.

Pre-Tax Election of Benefits

Premium Conversion (Pre-Tax Payroll Deduction of Insurance Premiums) - I understand by electing this option, my share of the premium under the plan(s) chosen will be deducted from my paycheck on a **pre-tax** basis. I understand that if I do not elect Premium Conversion, my share of the premium under the plan(s) will be deducted from my paycheck on an **after-tax** basis. I also understand that if my premium obligation increases or decreases during the Plan Year, my salary reduction will be adjusted automatically. The amount(s) of my required premium contribution for each plan has been provided in such other plan materials provided by *the Pelham School District.*

I hereby elect to participate in Premium Conversion for the following plan(s): **(please initial)** _____ Medical _____ Dental

Flexible Spending Account Elections

HealthCare FSA (Please select one below)

Annual Amount, if enrolled (up to $3,200)

Enroll ☐ $ _____

Waive ☐

The HealthCare and Dependent Care FSA benefits are deducted in 20 installments beginning on 9/12/2024 and ending on 6/5/2025. They are an deducted from your paycheck on a pretax basis.

Dependent Care FSA (Please select one below)

Annual Amount, if enrolled (up to $5,000 Per Household)

Enroll ☐ $ _____

Waive ☐

By signing below, I agree that I have made the selection(s) above. I understand that any changes elected or new elections are not complete until the proper HealthTrust Medical/Dental Application and Change Form and/or FSA Enrollment Form is received by Human Resources/Payroll. I also understand that if there is a discrepancy between an FSA amount listed on this election form and an amount listed on the Enrollment form, the amount listed on the Enrollment form will take precedent and no changes can be made once the enrollment form is submitted.

Employee Signature: _____ **Date :** _____

Revised 5/3/2024