# HEALTH BENEFITS SELECTION WORKSHEET 2016 – 2017

Use this sheet to complete your benefits selections. Then, go to myenroll.com and enter the information.

| Monthly Flex Credits | | Flex Credits | COST |
|---|---|---|---|
| ($836.00) | Monthly Flex Benefits Credit if you elect medical | | |
| ($100.00) | Monthly Flex Benefits Credit if you waive medical — *enter flex credit here* → | | |

## Medical Plans – required unless you have other current Medical Coverage

| Benefit Selection | Employee only | Employee *and* Spouse | Employee *and* Child(ren) | Employee *and* Family | |
|---|---|---|---|---|---|
| Kaiser EPO | 768.00 | 1013.00 | 914.00 | 1142.00 | |
| UHC PPO 500 | 768.00 | 1038.00 | 936.00 | 1185.00 | |
| UHC PPO 250 | 828.00 | 1049.00 | 961.00 | 1222.00 | |
| | | | | Before tax – *enter cost here* → | |

## Dental / Vision – required

| | | | | | |
|---|---|---|---|---|---|
| Reta Delta Dental | 91.00 | 123.00 | 107.00 | 140.00 | |
| Willamette Dental | 65.00 | 89.00 | 78.00 | 101.00 | |
| Kaiser Permanente Dental | 82.00 | 121.00 | 105.00 | 137.00 | |
| Vision - RETA VSP | (included) | (included) | (included) | (included) | |
| | | | | Before tax – *enter cost here* → | |

## Additional Life /AD&D - Optional

To enroll family members, you must select coverage for yourself. See rate sheet for premiums and the schedule of age based premium increases.

| | | | | | |
|---|---|---|---|---|---|
| **Employee coverage amount** $_____ (Cannot exceed lesser of $500,000 or 5 x annual wages. Do not include your basic life AD&D amount here.) | | | | After tax – *enter cost here* → | |
| **Spouse coverage amount** $_____ (Cannot exceed 100% of employee coverage) | | | | After tax – *enter cost here* → | |
| **Child(ren) coverage amount** (Cannot exceed 100% of employee coverage) | $1.80 ($6,000.00) | $2.40 ($8,000.00) | $3.00 ($10,000.00) | After tax – *enter cost here* → | |

## Short Term Disability - Optional

| | | | | | | |
|---|---|---|---|---|---|---|
| *44-day STD is automatic at initial enrollment if you don't opt out* | $0.00 OPT OUT | $7.98 STD 14-day | $5.64 STD 30-day | $3.28 STD 44-day | After tax – *enter cost here* → | |

## Buy-Up Long Term Disability – Optional

| | | | | |
|---|---|---|---|---|
| LTD - 60% of wages $6.62 | LTD - 66 2/3% of wages $9.75 | After tax – *enter cost here* → | |

## Healthcare Flexible Spending Account "FSA" – Optional

If you elect this coverage, a pro rata portion of your annual election will be deducted from each of the 12 remaining pay periods in the plan year.

| | | |
|---|---|---|
| **Monthly election amount** $_____ (Maximum election is $2,550.00 per year, or $212.50 per month.) | Before tax – *enter cost here* → | |

## Total of Credits and Costs

| | |
|---|---|
| Sum of Coverage Costs (add amounts in Cost column from above and enter here) → | |
| Flex Credit Amount (from above) → | |
| **Total Cost to Employee** (Sum Coverage Costs minus Flex Credit Amount) → | |