Luzerne County Head Start, Inc.

IRC Section 125 Flexible Benefits Plan
Enrollment Form
For Salaried & Hourly Employees

Plan Year
July 2019 - June 2020

Employee Name: _____
(Please Print Clearly)

*****Business Use Only:**

Pay Dates: _____ MS:$_____/Pay MS: $_____ Total

CO Amount: $_____ DC:$_____/Pay DC: $_____ Total

HE Amount: $_____ Health Coverage: _____ Dental Coverage:_____

Vision Amount: $_____ Vision Coverage:_____

Luzerne County Head Start, Inc., Full Time Employees
IRC Section 125: Flexible Benefits Plan Enrollment Form
Effective: July 1, 2019

EMPLOYEE INFORMATION

Print Name: _____ Social Security Number: _____

Position: _____ Center Location: _____

Check (√) Appropriate Lines:

12 Month Employee:_____ New Employee:_____

10 Month Employee:_____ Open Enrollment:_____

Change in coverage (from previous Plan Year):_____

Change in coverage (outside open enrollment):_____

>***IF Change***, Qualifying Event for Change:_____

_____

TAX TREATMENT

If choosing medical coverage or contributing to a flexible spending account, you must select the tax treatment of your contributions:

Check (√) one:

Pre-Tax (with Tax Savings): _____

After Tax (without Tax savings): _____

CASH-OUT

If choosing to waive medical coverage and **Cash Out** of the medical plan, you must provide proof of additional coverage:

Employer/Plan Sponsor: _____

Insurance Company: _____

Policy Number: _____

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts: You may contribute Pre-Tax payroll funds to pay for qualified, unreimbursed Medical and Dependent Care Expenses.

	Medical Spending	Dependent Care Spending	Total Contribution
Annual Election:	$_____ *($2,700 annual max)*	$_____ *($5,000 annual max)*	$_____

In order to calculate your per pay reductions, please check your pay schedule and divide your annual election by:

[ ] 26 pays for 12-Month employees ….. or …….. [ ] 20 pays for all 10-Month employees

Per Pay: (26 or 20 pays):	$_____	$_____	$_____

*** NEW FLEXIBLE SPENDING ACCOUNTS (FSAs) FEATURES ***

- Debit Cards and Participant Portal—Medical FSA Debit Card and On-Line Participant Portal
- $500 Carryover —Participants can "carryover" up to $500 of unused Medical FSA funds to next Plan Year

- Refer to the Summary Plan Description for more information.

- FSA Participants may schedule a meeting with a DeHEY McANDREW representative for an explanation of the new debit cards and participant portal. Contact DeHEY McANDREW at 800-353-9436 or 570-346-9960.

Choose your coverage option below:

***Note:** All 10 month employees will have 20 health insurance deductions or cash out payments, regardless of academic school year schedules that may result in more pay dates.

1. **12 month Employees (26 Pays)**
2. **10 Month Employees with Jump Start Coverage**
3. **10 Month Employees *Electing Summer Coverage* (20 Pays)**

#1

12-Month 26 Pay Employees

Plan: Geisinger Solutions Extra HMO

	w EE Dent	w EC Dent	w ES Dent	w FAM Dent	w No Dent	C/O	C/O w Dent
Employee Only (EE):	[ ] -$35.00	[ ] -$50.00	[ ] -$48.00	[ ] -$66.00	[ ] -$33.00	[ ] +$99.00	[ ] +$97.00 (EE)
EE & Child(n) (EC):	[ ] -$57.00	[ ] -$72.00	[ ] -$71.00	[ ] -$88.00	[ ] -$55.00	[ ] +$99.00	[ ] +$82.00 (EC)
EE & Spouse (ES):	[ ]-$150.00	[ ]-$165.00	[ ]-$164.00	[ ]-$182.00	[ ] -$148.00	[ ] +$99.00	[ ] +$84.00 (ES)
Family (FAM)	[ ]-$160.00	[ ]-$175.00	[ ]-$174.00	[ ]-$192.00	[ ] -$159.00	[ ] +$99.00	[ ] +$66.00 (FAM)

Pay Dates: July 14, 2019 through June 26, 2020

#2

10-Month Employees with Jump Start Coverage

Plan: Geisinger Solutions Extra HMO

	w EE Dent	w EC Dent	w ES Dent	w FAM Dent	w No Dent	C/O	C/O w Dent
Employee Only (EE):	[ ] -$45.00	[ ] -$65.00	[ ] -$63.00	[ ] -$86.00	[ ] -$43.00	[ ] +$129.00	[ ] +$127.00 (EE)
EE & Child(n) (EC):	[ ] -$74.00	[ ] -$94.00	[ ] -$92.00	[ ] -$115.00	[ ] -$72.00	[ ] +$129.00	[ ] +$107.00 (EC)
EE & Spouse (ES):	[ ]-$193.00	[ ]-$215.00	[ ]-$213.00	[ ]-$236.00	[ ] -$195.00	[ ] +$129.00	[ ] +$109.00 (ES)
Family (FAM)	[ ]-$208.00	[ ]-$228.00	[ ]-$226.00	[ ]-$249.00	[ ] -$206.00	[ ] +$129.00	[ ] +$86.00 (FAM)

Pay Dates September 6, 2019 through May 29, 2020

#3

**** IMPORTANT NOTE REGARDING CHANGE IN DEDUCTION****

Employees in this category receive coverage for all twelve months throughout the Plan Year, but are only ten (10) month employees. As such, employees in this category will have two (2) separate payroll deductions throughout the ten (10) months in which paid.

The first deduction will be your contribution for the Summer months in which you have coverage but do not make payroll contributions. The second deduction for a higher amount will be for the coverage throughout the ten (10) months in which you do not receive pay. The below tiers reflect the two (2) separate payroll reductions. For Example, the below contributions for Employee Only Medical with Individual Dental shows deductions of "$7/$36". Individuals electing this coverage tier will have a payroll deduction of $7 toward the Summer months of coverage and a $36 payroll deduction toward coverage throughout the other ten (10) months. Individuals electing this example of coverage would have a $7 and $36 deduction for a total of $43 throughout their twenty (20) payrolls.

10-Month 20 Pay Employees Includes Summer Coverage

Plan: Geisinger Solutions Extra HMO

	w Ind Dent	w EC Dent	w ES Dent	w FAM Dent	w No Dent	C/O	C/O w Dent
Employee Only (EE):	[ ]- $8/$38	[ ]- $11/54	[ ] -$10/$52	[ ] -$14/$72	[ ] -$7/$36	[ ] +$129	[ ] +$127 (EE)
EE& Child(n) (EC):	[ ]- $56/$62	[ ]- $59/78	[ ] -$59/$77	[ ] -$63/$96	[ ] -$55/$60	[ ] +$129	[ ] +$107 (EC)
EE & Spouse (ES):	[ ]-$108/$163	[ ]-$111/$179	[ ]-$111/$177	[ ]-$114/$197	[ ]-$107/$161	[ ] +$129	[ ] +$109 (ES)
Family (FAM):	[ ]-$130/$174	[ ]-$133/$190	[ ]-$133/$188	[ ]-$136/$208	[ ]-$129/$172	[ ] +$129	[ ] +$ 86 (FAM)

Pay Dates September 6, 2019 through May 29, 2020

SECTION ONLY FOR HIPP PARTICIPANTS

-ONLY HIPP PARTICPANTS COMPLETE THIS SECTION-

(Check Appropriate Health and/or Dental Coverage)

Health Insurance	Dental Insurance	Vision Insurance
[ ]Employee Only	[ ]Employee Only	[ ]Employee Only
[ ]Employee/Child(ren)	[ ]Employee/Child(ren)	[ ]Employee/Child(ren)
[ ]Employee/Spouse	[ ]Employee/Spouse	[ ]Employee/Spouse
[ ]Family	[ ]Family	[ ]Family

VOLUNTARY VISION PLAN

12-Month 26 Pay Employees

Plan: Vision Plan

	Per Pay
Employee Only (EE):	[ ] -$ 2.95
Employee & Child(n) (EC):	[ ] -$ 4.72
Employee & Spouse (ES):	[ ] -$ 4.82
Family (FAM)	[ ] -$ 7.77

Pay Dates: July 14, 2019 through June 26, 2020

10-Month 20 Pay Employees
Includes Summer Coverage

Plan: Vision Plan

	Per Pay
Employee Only (EE):	[ ] -$ 3.83
Employee & Child(n) (EC):	[ ] -$ 6.14
Employee & Spouse (ES):	[ ] -$ 6.26
Family (FAM):	[ ] -$10.10

Pay Dates September 6, 2019 through May 29, 2020

Signature Requirements: In signing this form, I am stating that I understand and agree to the following:

1. I authorize the above selections and/or pre-tax contributions, if applicable;
2. (Eligible Employees Only) If I have selected Cash in lieu of medical coverage, I certify that I have adequate medical coverage for myself and my dependents elsewhere.* I agree that if I lose my medical coverage, I will notify Luzerne County Head Start (LCHS) within 30 days from the loss of coverage date, and will join the Plan at that time;
3. I agree that if I have a life event (marriage, death, birth of a child, divorce or loss of coverage), I will notify LCHS within 30 days if I wish to change my elections;
4. I understand that certain benefits require insurance applications and that if I do not complete the required forms, I may not have insurance coverage;
5. If contributing to the cost of Medical Plan coverage, I have been apprised of my selection's cost and also agree to contribute to the cost of any increases imposed by the insurer during this Plan Year;
6. I understand that if I am waiving Medical Plan coverage, the Cash Allowance is subject to state, local and Federal taxes;
7. I understand that Medical Plan premiums are subject to change, based upon the requirements of the Insurer; and
9. I understand that if I am a 10 month employee and I elect insurance coverage during the summer, I am responsible for the cost of the coverage should I terminate employment before the cost of the coverage is fully repaid to the agency through payroll deduction. This cost is spread out September-June. If I terminate employment, I authorize LCHS to withhold such costs from my final paycheck. In the event that any funds still remain due and payable, I agree to that LCHS, Inc. may bill me for these costs, and I will repay the funds as billed.

Signature: _____

Date: _____