READY SEAFOOD CO.
2024 BENEFIT ELECTION FORM (Effective 7/1/2024)

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

	Harvard Pilgrim		
	OPTION #1	**OPTION #2**	**OPTION #3**
	Maine's Choice HMO 2000	**Best Buy HMO HSA 6000**	**PPO Ded Tiered Copay 4000**
DEDUCTIBLE			
IN NETWORK Single/Family	$2,000/$4,000 (Preferred)	$6,000/$12,000	$4,000/$8,000
OUT OF NETWORK Single/Family	$5,000/$10,000 (Standard)	N/A	$8,000/$16,000
TOTAL OUT OF POCKET			
IN NETWORK Single/Family	$5,500/$11,000 (Preferred)	$6,450/$12,900	$6,600/$13,200
OUT OF NETWORK Single/Family	$6,850/$13,700 (Standard)	N/A	$12,000/$20,000
COINSURANCE			
IN NETWORK/ OUT OF NETWORK	20% (Preferred) / 40% (Standard)	20% (IN)	20% (IN) / 40% (OUT)
PHYSICIAN OFFICE VISIT			
PRIMARY CARE VISIT	$35 (Preferred) / $50 (Standard)	DED + COINS (IN)	$30 (Tier 1) / $50 (Tier 2)
SPECIALIST VISIT	$35 OR $50 (Preferred)	DED + COINS (IN)	$30 (Tier 1) / $50 (Tier 2)
PREVENTIVE CARE (Routine Annual Physical & Gyn Exam)	COVERED IN FULL (IN)	COVERED IN FULL (IN)	COVERED IN FULL (IN)
COVERED SERVICES			
DIAGNOSTIC TESTING	DED + COINS	DED + COINS (IN)	DED + COINS
IMAGING (MRI/CAT/PET SCAN)	DED + COINS	DED + COINS (IN)	DED + COINS
OUTPATIENT SURGERY	DED + COINS	DED + COINS (IN)	DED + COINS
EMERGENCY ROOM	$300	DED + COINS	$250
INPATIENT HOSPITAL	DED + COINS	DED + COINS (IN)	DED + COINS
PHYSICAL, SPEECH & OCC. THERAPY	$50 (Preferred /60 visits/yr)	DED + COINS (IN)	$50 (60 visits/yr)
CHIROPRACTIC CARE	$35 (Preferred / 40 visits/yr)	DED + COINS (IN)	DED + COINS (IN)
PRESCRIPTION DRUGS			
RX DEDUCTIBLE	N/A	COMBINED WITH MEDICAL	N/A
TIER 1 / TIER 2 / TIER 3 / TIER 4	$10$35/$60/30%- $250 Script Max	DED then $10/$35/$60/30%-$250 Script Max	$10$35/$60/30%-$250 Script Max
90 DAY SUPPLY - MAIL ORDER	2 COPAYS / Tier 4: $500 Script Max	2 COPAYS / Tier 4: $500 Script Max	2 COPAYS / Tier 4: $500 Script Max
PREVENTIVE RX	N/A	YES, DEDUCTIBLE WAIVED	N/A

WEEKLY MEDICAL RATES			
EMPLOYEE	$35.10	$0.00	$37.51
EMPLOYEE + SPOUSE	$130.04	$62.10	$134.80
EMPLOYEE + CHILD(REN)	$115.09	$52.24	$119.50
FAMILY	$221.17	$115.86	$228.56

WEEKLY DENTAL RATES	**Base Dental Plan**	**Buy-Up Dental Plan**
EMPLOYEE	$7.40	$9.63
EMPLOYEE + SPOUSE	$15.20	$19.84
EMPLOYEE + CHILD(REN)	$18.63	$24.84
FAMILY	$26.43	$35.03

WEEKLY VISION RATES	
EMPLOYEE	$1.59
EMPLOYEE + SPOUSE	$3.17
EMPLOYEE + CHILD(REN)	$3.25
FAMILY	$4.83

Employee Name

READY SEAFOOD CO.
July 1, 2024

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

MEDICAL, DENTAL & VISION ELECTIONS

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
MEDICAL: ME Choice HMO				
MEDICAL: HSA-HMO				
MEDICAL: PPO 4000				

	PCP Name	City
If HMO plan selected— Insert PCP information		

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
DENTAL BASE PLAN				
DENTAL BUY-UP PLAN				
VISION PLAN				

HEALTH SAVINGS ACCOUNT(HSA) **taken out on pre-tax basis **WEEKLY ELECTION AMOUNT**

2024 Contribution Limit: individual-$4,150/Family-$8,300 weekly max: ind-$79.81/fam- $159.62
2025 Contribution Limit: individual-$4,300/Family-$8,550 weekly max: ind-$82.69/fam- $164.42
If over age 55 $1,000 catch up contribution allowed per year

_____

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**