# 2024 BENEFITS & PREMIUM RATES

**Employee Name:** _____ **Division:** _____

**Hire Date:** **Effective Date:**

| MEDICAL-HSA HIGH DEDUCTIBLE PLAN | MONTHLY PREMIUM RATES – [Tier 1: Salary <$56,325 / Tier 2: Salary >$56,325] |
|---|---|
| ☐ **Single Employee** | Standard rate - **$99.44 / $99.44** Discounted rate (Tobacco-free) - **$69.61 / $69.61**<br>Discounted rate (Health screening) - **$79.54 / $79.54** Discounted rate (Health screening **AND** Tobacco-free) - **$49.72 / $49.72** |
| ☐ **Employee + Spouse only** | Standard rate - **$124.80 / $148.96** Discounted rate (Tobacco-free) - **$87.36 / $104.27**<br>Discounted rate (Health screening) - **$99.84 / $119.17** Discounted rate (Health screening **AND** Tobacco-free) - **$62.40 / $74.48** |
| ☐ **Employee + Children only** | Standard rate - **$120.32 / $138.22** Discounted rate (Tobacco-free) - **$84.23 / $96.76**<br>Discounted rate (Health screening) - **$96.26 / $110.58** Discounted rate (Health screening **AND** Tobacco-free) - **$60.16 / $69.11** |
| ☐ **Full Family** | Standard rate - **$275.45 / $400.74** Discounted rate (Tobacco-free) - **$192.81 / $280.52**<br>Discounted rate (Health screening)-**$220.36 / $320.59** Discounted rate (Health screening AND Tobacco-free)-**$137.72 / $200.37** |
| **MEDICAL – PPO PLAN** | **MONTHLY PREMIUM RATES – [TIER 1 / TIER 2]** |
| ☐ **Single Employee** | Standard rate - **$328.15 / $328.15** Discounted rate (Tobacco-free) - **$229.71 / $229.71**<br>Discounted rate (Health screening)-**$262.52 / $262.52** Discounted rate (Health screening **AND** Tobacco-free)-**$164.08 / $164.08** |
| ☐ **Employee + Spouse only** | Standard rate - **$578.12 / $602.28** Discounted rate (Tobacco-free) - **$404.68 / $421.60**<br>Discounted rate (Health screening)-**$462.50 / $481.82** Discounted rate (Health screening **AND** Tobacco-free)-**$289.06 / $301.14** |
| ☐ **Employee + Children only** | Standard rate - **$530.49 / $548.39** Discounted rate (Tobacco-free) - **$371.34 / $383.87**<br>Discounted rate (Health screening)-**$424.39 / $438.71** Discounted rate (Health screening **AND** Tobacco-free)-**$265.24 / $274.19** |
| ☐ **Full Family** | Standard rate - **$923.13 / $1048.43** Discounted rate (Tobacco-free) - **$646.19 / $733.90**<br>Discounted rate (Health screening)- **$738.50 / $838.74** Discounted rate (Health screening **AND** Tobacco-free)-**$461.57 / $524.21** |
| ☐ **WAIVE MEDICAL INSURANCE** | Indicate reason for waiving coverage here: _____ |
| **DENTAL INSURANCE** | |
| ☐ **Single Employee**<br>☐ **Family Coverage**<br>☐ **WAIVE DENTAL INSURANCE** | $50 Deductible per person per year – Diagnostic & Preventive Services paid at 100% (90% out of network);<br>Basic Services paid at 80% (70% out of network); Major Services paid at 50% (40% out of network);<br>Orthodontia paid at 50% to lifetime maximum of $1,000 (in network only)<br>**Single Coverage - $36.83** **Family Coverage - $73.67** |
| **VISION INSURANCE** | |
| ☐ **Single Employee *(Select one of the 4 plans)***<br>☐ **Family Coverage *(Select one of the 4 plans)***<br>☐ **WAIVE VISION INSURANCE** | **There are 4 plans available:**<br>☐ Core Plan A – **Single $8.92; Family $20.71**<br>☐ Core Plan A + Lens Option – **Single $12.44; Family $28.82**<br>☐ Buy-Up Plan B – **Single $11.80; Family $27.11**<br>☐ Buy-Up Plan B + Lens Option – **Single $14.33; Family $33.23** |

| LIFE/AD&D INSURANCE | |
|---|---|
| **Employee Life and Accidental Death & Dismemberment (AD&D) Insurance** | Enrolled at no cost for $50,000 coverage (CTI pays 100% of the premium) |
| **Employee Supplemental Life Insurance** | ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000<br>May elect in $25,000 increments, to a maximum benefit of $150,000 ☐ Waive Supp. Life<br>*Rates vary by age – See Voluntary Life Insurance handout on CTI Intranet.* |
| **Spouse Supplemental Life**<br>*(You must also elect Employee Supp. Life to select this option.)* | May elect in $5,000 increments, to a maximum benefit of $75,000 Benefit amount $_____<br>*May elect up to one-half of the amount of Employee Supplemental Life* ☐ Waive Spouse Supp. Life<br>*Rates vary by age – See Voluntary Life Insurance handout on CTI Intranet.* |
| **Child Supplemental Life**<br>*(You must also elect Employee Supp. Life to select this option.)* | May elect benefit amount of : ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Waive Child Supp. Life<br>*See Voluntary Life Insurance handout on CTI Intranet.* |
| **Employee Supplemental Accidental Death & Dismemberment (AD&D)** | May elect a benefit amount in $25,000 increments, to a maximum benefit of $500,000; may choose Employee Only or Family Plan. *See Voluntary AD&D Insurance handout on CTI Intranet.* **Benefit Amount**: $_____<br>☐ Employee Only Plan (Rate is $0.03 per $1,000 of coverage) ☐ Family Plan (Rate is $0.05 per $1,000 of coverage)<br>☐ Waive Supplemental AD&D |
| **SHORT/LONG-TERM DISABILITY** | |
| **Short-Term Disability** | Enrolled at no cost for 60% of weekly earnings to $300 maximum benefit ($500 maximum if over 5 years of service)<br>*(Note: There is a one-year waiting period for this benefit).* |
| **Long-Term Disability** | ☐ May elect benefit of 60% of monthly earnings to a $5,000 maximum benefit) ☐ Waive Long Term Disability<br>*(Rate is calculated based on age and salary – See separate rate sheet.)* |
| **Critical Illness Insurance** | Employee may elect: ☐ **$10,000** ☐ **$20,000** benefit<br>Spouse may elect: ☐ **$5,000** ☐ **$10,000** benefit ☐ Waive Critical Illness<br>*Rates vary both by tobacco user status and by age; see benefit and rate information in handout on CTI Intranet.* |
| **HEALTH SAVINGS ACCOUNTS and FLEXIBLE SAVINGS ACCOUNTS** | |
| **Health Savings Account**<br>*(Note: Must establish account at UMB Healthcare Services – see separate form with instructions)* | ☐ Monthly Contribution Amount: $_____ ☐ Waive HSA<br>(Amount per paycheck: $_____) |
| **Flexible Spending Account - Health Care**<br>*(Must complete FSA enrollment form)* | ☐ Monthly Election Amount: $_____ ☐ Waive Health Care FSA<br>(Amount per paycheck: $_____) |
| **Flexible Spending Account - Dependent Care**<br>*(Must complete FSA enrollment form)* | ☐ Monthly Election Amount: $_____ ☐ Waive Dependent Care FSA |

# 2024 BENEFIT ELECTION FORM

SOCIAL SECURITY NUMBERS ARE REQUIRED ON EACH DEPENDENT. PLEASE BE SURE TO PROVIDE YOUR DEPENDENTS' SOCIAL SECURITY NUMBERS BELOW.
**Medical/Dental/Vision Dependents** include your lawful, current spouse (if they are not eligible for benefits through their own employer), your son, daughter, stepchild, adopted child, eligible foster child, or a child for whom you have been appointed legal guardian, regardless of whether the dependent is married or unmarried, under the age of 26. Spouses and children of eligible dependents are not considered eligible.

| EMPLOYEE'S FULL NAME/ ADDRESS/PHONE | Social Security Number | Date of Birth | Gender (Male/Female) | Employee, Spouse, or Child | If Child, is he/she your legal dependent? |
|---|---|---|---|---|---|
| **Name:** _____<br>**Address:** _____<br>_____<br>**Phone:** _____ | | | | | |
| **DEPENDENTS' FULL NAMES:** | | | | | |
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By signing this form, I acknowledge and agree to pre-tax payroll contributions, if applicable, and understand that my participation and benefits are subject to applicable plan documents and IRS rules and may not be changed at any time during the plan year unless I experience a qualifying event as defined by the IRS. I acknowledge that falsification of information may result in disciplinary action, up to and including termination. I certify that the information provided here is correct and the listed dependents qualify for benefits according to the benefit plan documents and the IRS rules.

_____ _____ _____

**Employee Signature** **Printed Name** **Date**