Gilman School District
Benefit Election Form:
Security Health Plan - Effective 9/1/2017

JOHNSON INSURANCE

Forms MUST be returned By: SEPTEMBER 1, 2017

Employee Name:

Social Security # :

OPTION Medical Network	Option #1 ☐	Option #1A ☐	Option #2 ☐	Option #2A ☐
MEDICAL BENEFITS	**SHP HMO - $5000 with HRA**	**SHP POS - $5000 with HRA**	**SHP HMO - $5000**	**SHP POS - $5000**
Deductible:				
In Network:	$5,000 Single $10,000 Family	$5,000 Single $10,000 Family	$5,000 Single $10,000 Family	$5,000 Single $10,000 Family
Out of Network:	N/A	$10,000 Single $20,000 Family	N/A	$10,000 Single $20,000 Family
HEALTH REIMBURSEMENT	$2,400 Single / $4,800 Family	$2,400 Single / $4,800 Family		
Coinsurance:				
In Network:	100%	100%	80%	80%
Out of Network:	N/A	80%	N/A	60%
Out-of-Pocket Maximum:				
In Network:	$5,000 Single $10,000 Family	$5,000 Single $10,000 Family	$6,550 Single $13,100 Family	$6,550 Single $13,100 Family
Out of Network:	N/A	$11,000 Single $22,000 Family	N/A	$13,100 Single $26,200 Family
In Network Office Copay:	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Deductible:	With Medical	With Medical	With Medical	With Medical
Prescription Drug Copay: Tier 1/ 2 / 3	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Hospital In/Out Patient:	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care In Network:	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Care In Network:	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Monthly Cost: (Mark your level of coverage)				
Employee	☐ $78.50	☐ $106.60	☐ $55.00	☐ $81.71
Family	☐ $178.19	☐ $241.98	☐ $105.00	☐ $165.63

WAIVER

☐ By checking this box, I will be waiving Health coverage.

Acknowledgement and Consent

I certify that the answers on this form are complete and are part of the request for coverage under the Group Policy

EMPLOYEE SIGNATURE **Date**