2021 MEDICAL DEDUCTION FORM – WEEKLY PAYROLL ONLY

Name_____ Facility/Program _____

Instructions: If you are participating in the wellness program circle the deduction applicable to you in the box under "2021 Wellness Contributions". If you are NOT participating in the wellness program circle the deduction in the lower box under "2021 Non-Wellness Contribution" If you are waiving medical, and wish to elect dental/vision only, see bottom of page 2.

2021 WEEKLY WELLNESS CONTRIBUTION

YES to WELLNESS ☐

Salary Level	Coverage	EPO Opt 1	PPO Opt 2	EPO Opt 3
Under $44,000	Single	$28.87	$29.28	$6.39
	Care Member + 1	$57.11	$56.83	$7.84
	Family	$87.01	$88.00	$9.44
$44,001–$66,000	Single	$34.10	$35.20	$6.78
	Care Member + 1	$67.50	$68.60	$8.62
	Family	$102.32	$105.37	$10.59
$66,001–$100,000	Single	$42.79	$41.11	$7.44
	Care Member + 1	$84.80	$80.37	$9.92
	Family	$126.26	$122.73	$12.39
$100,001–$160,000	Single	$46.28	$44.07	$7.70
	Care Member + 1	$91.73	$86.25	$10.44
	Family	$138.09	$131.41	$13.28
$160,001+	Single	$51.50	$48.50	$8.09
	Care Member + 1	$102.13	$95.07	$11.22
	Family	$153.42	$144.43	$14.43

2021 WEEKLY NON-WELLNESS CONTRIBUTION

NO to WELLNESS ☐

Salary Level	Coverage	EPO Opt 1	PPO Opt 2	EPO Opt 3
Under $44,000	Single	$53.56	$53.97	$31.08
	Care Member + 1	$81.80	$81.52	$32.53
	Family	$111.70	$112.69	$34.13
$44,001–$66,000	Single	$58.79	$59.89	$31.47
	Care Member + 1	$92.19	$93.29	$33.31
	Family	$127.01	$130.06	$35.28
$66,001–$100,000	Single	$67.48	$65.80	$32.13
	Care Member + 1	$109.49	$105.06	$34.61
	Family	$150.95	$147.42	$37.08
$100,001–$160,000	Single	$70.97	$68.76	$32.39
	Care Member + 1	$116.42	$110.94	$35.13
	Family	$162.78	$156.10	$37.97
$160,001+	Single	$76.19	$73.19	$32.78
	Care Member + 1	$126.82	$119.77	$35.91
	Family	$178.11	$169.12	$39.12

WELLNESS AGREEMENT

*As a reminder, it is your choice to participate or not participate in ArchCare's Wellness Program. Participation in the program entitles you to the wellness care member contribution rate, as well as a Health Reimbursement Account (HRA). Be advised that by electing to participate in the Wellness Program, you are agreeing to meet the quarterly requirements as outlined by the program. Specifically, you are required to earn 250 points by the last day of each quarter (3/31, 6/30, 9/30, 12/31). Should you fail to meet the requirements of the program in a given quarter, your participation in the program will be discontinued. Effective the following quarter, your care member contributions will be increased to the non-wellness rate, you will no longer be eligible to receive HRA money, *and you will be required to pay back the difference in contribution (wellness/non-wellness) for the quarter in which you did not meet the requirement. *the difference in contribution will be calculated and deducted from your paychecks throughout the following quarter.*

SALARY REDUCTION AGREEMENT

I hereby authorize ArchCare, if necessary, to deduct the cost of coverage from my weekly paychecks. I understand that the coverage I have elected will remain in force from January 1, 2021 to December 31, 2021, unless family status changes.

Care Member Signature: _____

Date: _____

THIS SECTION IS ONLY FOR CARE MEMBERS WHO WAIVE MEDICAL INSURANCE AND ELECT DENTAL/VISION ONLY

WAIVE MEDICAL/ ELECTING DENTAL & VISION ONLY **Rates are per weekly pay*.

Select coverage level: ☐ **Single** *$2.50* ☐ **Employee+1** *$7.50* ☐ **Family** *$12.50*

SALARY REDUCTION AGREEMENT

I hereby authorize Archcare, if necessary, to deduct the cost of coverage from my bi-weekly paychecks. I understand that the coverage I have elected will remain in force from January 1, 2021 to December 31, 2021, unless family status changes.

Care Member Signature: _____

Date: _____