Payroll deductions

Arizona Fireplaces 3/1/2021 to 2/28/2022

Co.

Plan 1 - CIGNA Local Plus Network H.S.A. $4,000 100%/70%

	Monthly Rate	Employer Paid Monthly Amount	Employee Paid Monthly Amount	Employee Paid Per Paycheck (52 Pay Periods)
Medical EE	$349.54	$300.00	$49.54	$11.43
Medical EE & SP	$699.12	$400.00	$299.12	$69.03
Medical EE & CHILD	$681.62	$400.00	$281.62	$64.99
Medical FAMILY	$1,153.50	$600.00	$553.50	$127.73

Plan 2 - CIGNA Open Access Network PPO - $2,000 80%/50% $30/$45 Office Visit Co-Pays

Medical EE	$517.64	$300.00	$217.64	$50.22
Medical EE & SP	$1,035.29	$400.00	$635.29	$146.61
Medical EE & CHILD	$1,009.42	$400.00	$609.42	$140.64
Medical FAMILY	$1,708.22	$600.00	$1,108.22	$255.74

Plan 3 - CIGNA Open Access Network PPO - $500 100%/70% $25/$40 Office Visit Co-Pays

Medical EE	$595.87	$300.00	$295.87	$68.28
Medical EE & SP	$1,191.74	$400.00	$791.74	$182.71
Medical EE & CHILD	$1,161.94	$400.00	$761.94	$175.83
Medical FAMILY	$1,966.38	$600.00	$1,366.38	$315.32

Waiving Medical Coverage - Indicate reason for waiving coverage (circle reason if waiving)

I wish to decline medical coverage and not participate on the plan for the following reason:

A) Do not wish to be covered - no other coverage

B) Covered by spouse's or parent's employer group plan

C) Covered by TRICARE

D) Covered by AHCCCS

E) Covered by I.H.S. (Indian Health Services)

F) Covered by Medicare

G) Married and covered by fellow Arizona Fireplaces employee

H) Individual coverage purchased directly from carrier

I) Individual coverage purchased on Healthcare Marketplace

CIGNA DHMO - Low Option Dental

dental EE	$8.11	$0.00	$8.11	$1.87
dental EE & SP	$13.57	$0.00	$13.57	$3.13
dental EE & CHILD	$17.01	$0.00	$17.01	$3.93
dental FAMILY	$24.01	$0.00	$24.01	$5.54

CIGNA PPO High Option Dental Plan

dental EE	$35.58	$0.00	$35.58	$8.21
dental EE & SP	$74.73	$0.00	$74.73	$17.25
dental EE & CHILD	$77.29	$0.00	$77.29	$17.84
dental FAMILY	$121.45	$0.00	$121.45	$28.03

Waving Dental Coverage - (circle if waiving dental coverage)

I wish to decline dental coverage and not participate on the plan.

CIGNA Vision Plan

vision EE	$7.43	$0.00	$7.43	$1.71
vision EE & SP	$13.19	$0.00	$13.19	$3.04
vision EE & CHILD	$13.32	$0.00	$13.32	$3.07
vision FAMILY	$20.25	$0.00	$20.25	$4.67

Waving Vision Coverage - (circle if waiving vision coverage)

I wish to decline vision coverage and not participate on the plan.

Please circle appropriate payroll deduction then sign, date and return to the HR Department.

Employee Name (Print)

Employee Signature Date