

# Rochester Community Schools – Paraeducators (Hired/Eligible after 8/1/11)

## 2025 Election Form – Plan Year: January 1, 2025 – December 31, 2025

Complete only if you are making changes, newly enrolling, opting-out of medical or contributing to a Flexible Spending Account

You must complete all sections of this form, regardless if you are already covered under the plan

### EMPLOYEE INFORMATION

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Name \_\_\_\_\_ DEN# \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ Date of Hire \_\_\_\_\_  
Street City State Zip Code

Email \_\_\_\_\_ Phone \_\_\_\_\_  Check box if address has changed from previous year

Date of Birth \_\_\_\_\_  Male  Female Work Location \_\_\_\_\_

### DEPENDENT INFORMATION - List those individuals to be covered under the Medical, Dental and/or Vision Plans

2

	LAST NAME	FIRST	GENDER	BIRTHDATE	MEDICAL	DENTAL	VISION
Spouse					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
Child					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
Child					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop
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Child					<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop

### BENEFIT SELECTIONS

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#### Medical Plan - Blue Cross Blue Shield of Michigan

Choose **one** of the following options

##### BCBSM PPO Medical Plan

- Single
- Single + 1
- Family

##### BCBSM HSA Medical Plan

- Single
- Single + 1
- Family

##### OPT-OUT OF MEDICAL COVERAGE

- Opt-Out - Taxable Income (Complete the Opt-Out Attestation of Other Coverage below)

If you choose to decline medical coverage, your opt-out incentive will be: 1-15 opt-outs \$50 per month; 16-24 opt-outs \$75 per month; 25+ opt-outs \$100 per month. The opt-out incentive will be distributed as taxable income. This amount will be taxed for federal, state, and Social Security.

<b>Per Pay – 20 Pay Cycle</b>
\$91.11
\$218.67
\$273.33
<b>Per Pay – 20 Pay Cycle</b>
\$84.51
\$199.51
\$245.27

3a

#### Opt-Out Attestation of Other Coverage - Please read and sign below

**If you or your dependents are enrolled in other coverage, you and your dependents may not enroll under our medical plan. In accordance with the union agreements, the school district will not provide dual and/or coordinated coverage.**

I understand my right to enroll for coverage for my eligible dependents and me. However, I have other coverage available to me for the plan year January 1, 2025 through December 31, 2025, and so I would like to waive coverage under the District's medical plan. I choose to decline medical and prescription drug coverage offered by Rochester Community Schools. By signing below, I attest I understand that the Patient Protection and Affordable Care Act, also called Health Care Reform requires most individuals to have health insurance or pay a penalty for non-compliance. All members of my Tax Family have or will have Minimum Essential Coverage for the entire plan year, January 1, 2025 through December 31, 2025. "Tax Family" includes you and all other individuals you reasonably expect to claim a personal exemption deduction for the taxable year or years covered by the opt-out time period. "Minimum Essential Coverage" is medical coverage that meets minimum standards under the Affordable Care Act. It does not include coverage purchased in the individual market, whether or not obtained through the Marketplace. I understand that I will have an opportunity to enroll for medical and prescription drug coverage during the next annual benefit enrollment period, or I may enroll for coverage before then if I qualify for a special enrollment period or have a qualifying change in status. I understand that to enroll for coverage during a special enrollment period or due to a qualifying change in status, I must request coverage from my employer within 30 days of the event. I understand that this Attestation is required annually to continue and I affirm the information I am providing is true and accurate to the best of my knowledge.

⇒ Signature \_\_\_\_\_

Date \_\_\_\_\_

Employee Name \_\_\_\_\_

**4 Dental and Vision Plans - Blue Cross Blue Shield of Michigan**  
 If you enroll in medical coverage, you will automatically be enrolled in the same dental and vision coverage tier as your medical election  
 If you opt-out of medical coverage, choose **one** of the following options

**BCBSM Dental and Vision Plans**

<input type="checkbox"/> Single	<b>Dental</b>	<b>Vision</b>
<input type="checkbox"/> Single + 1	\$47.86	\$3.11
<input type="checkbox"/> Family	\$114.88	\$7.47
	\$143.60	\$9.32

**5 Flexible Spending Accounts - Basic and Health Savings Account (HSA):**

	Maximum Annual Elections	Annual Election	Pay Period Frequency	Per Pay Amount
Health Care FSA <i>Limited FSA if enrolling in the HDHP</i>	\$3,300	\$ _____	26 or 21	\$ _____
Dependent Care FSA	\$5,000	\$ _____	26 or 21	\$ _____
Health Savings Account <i>Only available with HSA Medical Plan</i>	\$4,300 for single \$8,550 for family (minus any money contributed by Rochester Schools)	\$ _____	26 or 21	\$ _____

*Rochester Schools will contribute \$825 for single coverage or \$1,650 for family coverage if you enroll yourself and your dependent(s) in the HSA medical plan*

**6 Life and Accidental Death and Dismemberment – The Standard**  
 You must complete a Statement of Health, found on the Rochester Community Schools website, if your Optional Life/AD&D election is subject to evidence of insurability as detailed in the Benefit Guide

	Optional Life/AD&D Table		
	Age	Employee	Spouse
Basic Life and AD&D Plan - Rochester Schools provides Life and AD&D	Under 25	\$0.055	\$0.065
	25 – 29	\$0.055	\$0.075
	30 – 34	\$0.065	\$0.095
	35 – 39	\$0.085	\$0.105
	40 – 44	\$0.105	\$0.125
	45 – 49	\$0.155	\$0.185
	50 – 54	\$0.245	\$0.325
	55 – 59	\$0.405	\$0.525
	60 – 64	\$0.565	\$0.945
	65 – 69	\$1.005	\$1.605
	70+	\$1.625	N/A

**Employee** – may purchase Optional Life and AD&D insurance in increments of \$10,000 up to \$500,000, enter your election in the table below & calculate your cost  

$$\frac{\$ \text{ _____ } / \$1,000 \times \$ \text{ _____ }}{\text{Rate (Table)}} = \text{Cost per month}$$
*Must evenly divide \$10,000*

**Spouse** – may purchase Optional Life and AD&D insurance in increments of \$10,000 up to \$150,000, enter your election in the table below & calculate your cost  

$$\frac{\$ \text{ _____ } / \$1,000 \times \$ \text{ _____ }}{\text{Rate (Table)}} = \text{Cost per month}$$
*Must evenly divide \$10,000*

**Children** – may purchase Optional Life and AD&D insurance in increments of \$2,500 up to \$10,000, circle your election & cost below  

\$2,500	\$ 0.54	\$7,500	\$ 1.61
\$5,000	\$ 1.08	\$10,000	\$ 2.15

**BENEFICIARY INFORMATION** - If you want to change or update your beneficiary, please complete a The Standard Beneficiary form found on the Rochester Community Schools website

**7 SIGNATURE - Please read and sign below**

I wish to make the choices indicated on this form and authorize Rochester Community Schools to make any necessary pre-tax or after-tax payroll adjustments. I understand that these elections are effective January 1, 2025 through December 31, 2025. I understand that I am required to reimburse Rochester Community Schools for all elected benefits either during or after any authorized leave. I understand that Rochester Community Schools retains the right to amend, modify, or terminate this Plan at any time.

I understand that pre-tax contributions will slightly impact my social security contributions. I understand that I need to use any dollars I've deposited in the Health Care and Dependent Care Reimbursement Accounts by year-end or they will be forfeited. Adjustments may be necessary to comply with IRS discrimination tests. I am aware that the plan maximum may be reduced to maintain compliance with IRS regulations.

I understand that this election is irrevocable until next plan year unless there is an allowable change in family status that occurs and I notify Department of Human Resources within 30 days of the allowable change. I certify the information on this form is complete and accurate. Any person who, with intent to defraud or knowing that they are facilitating a fraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I understand there shall be no duplication of hospitalization benefit. I must notify the Department of Human Resources of any personal, duplicated benefit coverage – either through personal coverage or coverage from spouse's or family's benefit plan. If I am covered by any other duplicated hospitalization benefit, the Employer's obligations under this benefit shall be waived.

⇒ Signature \_\_\_\_\_ Date \_\_\_\_\_