DoveLewis Health Benefit Rate Sheet
January – December 2023

Employee (print name):_____ Effective Date: _____

Employees are eligible to participate in the DoveLewis benefit plan on the first of the month 30 days following their hire date.
Rates are listed as cost per month and are divided equally over two paychecks for each month.

Dental insurance is paid at 100% by DoveLewis. Rates for 2023 are as follows:

Dental	Select Coverage/Initial one of the boxes below	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Moda		$49.36	$97.73	$101.67	$154.98
Willamette		$49.36	$97.73	$101.67	$154.98

Full-time Employee (35+ hours weekly)

The employee's share of premiums is set up through payroll deductions with pre-tax dollars. **All costs are per month.**

Medical	Select Coverage/Initial one of the boxes below	Employee Cost	Company Cost	Total Cost
Employee Only		**$45.00**	$621.43	$666.43
Employee + Spouse		**$270.00**	$1,062.86	$1,332.86
Employee + Child(ren)		**$245.00**	$954.57	$1,199.57
Employee + Family		**$413.00**	$1,586.29	$1,199.29

Full-time 30 Employee (30+ hours weekly)

The employee's share of premiums is set up through payroll deductions with pre-tax dollars. **All costs are per month.**

Medical	Select Coverage/Initial one of the boxes below	Employee Cost	Company Cost	Total Cost
Employee Only		**$75.00**	$591.43	$666.43
Employee + Spouse		**$310.00**	$1,022.86	$1,332.86
Employee + Child(ren)		**$285.00**	$914.57	$1,199.57
Employee + Family		**$463.00**	$1,536.29	$1,999.29

Part-time Employees (24+ hours weekly)

The employee's share of premiums is set up through payroll deductions with pre-tax dollars. **All costs are per month.**

Medical	Select Coverage/Initial one of the boxes below	Employee Cost	Company Cost	Total Cost
Employee Only		**$236.00**	$430.43	$666.43
Employee + Spouse		**$680.00**	$652.86	$1,332.86
Employee + Child(ren)		**$610.00**	$589.57	$1,199.57
Employee + Family		**$1,008.00**	$991.29	$1,999.29

Full and Part-time Employees (24 - 40 hours weekly)

The employee's share of premiums is set up through payroll deductions with pre-tax dollars. **All costs are per month.**

Standard Vision	Select Coverage/Initial one of the boxes below	Employee Cost	Company Cost	Total Cost
Employee Only		**$10.96**	$0.00	$10.96
Employee + Spouse		**$23.64**	$0.00	$23.64
Employee + Child(ren)		**$19.08**	$0.00	$19.08
Employee + Family		**$31.76**	$0.00	$31.76

Election of Pre-Tax Benefits under the Salary Reduction Plan

On a separate benefit enrollment form(s), I have enrolled for medical and dental insurance coverage offered by DoveLewis. I understand that by making the above election for coverage, the premiums for the coverage that I elect will be deducted from my compensation on a pre-tax basis.

Elections Irrevocable Unless Exception Applies

I understand that I cannot change or revoke this Agreement as of any date prior to the next January 1, unless a Change in Election Event occurs as defined in the Plan (e.g. termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event, as described in the Plan.

Additional Terms

I agree that my compensation will be reduced by the amount of my required contribution for the Benefits I have elected under the Plan, and that such Salary Reductions will continue monthly until this Agreement is amended or terminated. The amount of my contribution for the Health Insurance Benefits that I have selected is set forth on the schedule above. I understand that my contribution rate will be automatically increased or decreased for any changes by the Administrator. Also, I understand that:

a) Signing this Agreement does not initiate my coverage under the insurance policies. I must complete a separate health insurance enrollment form to start my health insurance coverage.
b) Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.

☐ I have read and agree to the terms of participation set forth on this Agreement.

Employee Signature: _____ Date:_____

If waiving coverage please check the box below, sign and date

☐ I elect to waive coverage of the DoveLewis medical and dental insurance plan.

Employee Signature: _____ Date:_____