DAVISON COMMUNITY SCHOOLS
ELECTION FORM

Election Agreement and Pre-Tax Compensation Reduction Agreement Form
For Medicare Eligible Employees

Name: _____

Address, City, State: _____

I acknowledge that I have been given the opportunity to enroll myself and my dependents in group health coverage offered by the Davison Community Schools during the January 1, 2020 through December 31, 2020 plan year subject to my continued employment by the district.

I have been provided with an explanation of the Davison Community Schools Cafeteria Plan (the "Plan") and have had the opportunity to discuss this form with my own attorney or other advisor. After reviewing carefully the alternatives available to me under the Plan, I hereby select the Health Plan or Waive the Health Plan effective (Check One):

_____ Elect to receive qualified benefits under the MESSA Choices Health Plan.

_____ Elect to receive qualified benefits under the MESSA ABC Plan 1 Health Plan.

_____ Elect to receive qualified benefits under the Essentials by MESSA Health Plan.

I understand and agree that my pre-tax compensation will be reduced as provided herein to the extent necessary to pay the employee contribution portion of the premium for MESSA medical plan protection.

Employees who elect MESSA medical coverage will be required to contribute any amount of the premium that is above the “hard-cap” amounts negotiated by the District for employer contributions for health care costs.

_____ Elect to decline the opportunity to enroll in either self-only or self + dependents coverage.

I understand that:

- The district contribution is defined as the amount of premium cost up to but not to exceed the “hard cap” amount negotiated by the district for employer contributions for health care costs, and my contribution is equal to the difference between the cost of my elected plan and the district contribution.

(See Page 2.)

- I agree and consent to a reduction in my pre-tax compensation equal to the amount of the employee contributory premium costs for Health Plan coverage if I elect Health Plan coverage.
- I cannot change or revoke this benefit election agreement as of any date prior to the next enrollment effective date unless I have a change in family status (i.e., marriage, divorce, death of a spouse or dependent, birth or adoption of a child, commencement or termination of employment of my spouse, the switching from part-time to full-time employment status (or vice versa) by me or my spouse, the taking of an unpaid leave of absence by me or my spouse, a significant change in the health coverage of me or my spouse attributable to my spouse's employment, or such other events as the Administrator determines will permit a change or revocation of an election) or there is a significant increase or decrease in the cost of the qualified benefits or an option for qualified benefit coverage which I have selected. Any change in the benefit election agreement must be made within 31 days of the qualifying event and be permitted by the applicable insurance company(ies).
- Prior to each new plan year, I will be offered the opportunity to change my benefit election(s) for the following plan year. If I do not complete and return a new election form by the stated ending of the Open Enrollment period, I will be treated as having elected to continue any benefit coverage then in effect for the new plan year.
- The District may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the Plan if believed advisable in order to satisfy certain provisions of the Internal Revenue Code.
- If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pre-tax pay reduction will automatically be adjusted to reflect that increase or decrease.
- Unless I and my dependents have health coverage that satisfies my individual responsibility under the Affordable Care Act, I may be assessed a tax penalty for my failure to obtain coverage. I further understand that, even if I satisfy applicable household income requirements, I may not be eligible for a tax credit or subsidy for health coverage that I purchase on a health care exchange (Health Insurance Marketplace) for any month in which I was given the opportunity to participate in the District’s group health coverage as described above.

_____ _____

Date Employee's Signature