EMPLOYER RENEWAL
FASTER, EASIER & MORE SECURE ONLINE

Great news - we made your renewal easier! You can now pick the plans you want to offer and have your employees shop and enroll in their benefits online.

- Compare plan options side by side
- Built-in decision support
- No more paper forms
- Enrollment reports

IT'S QUICK AND EASY TO SET UP

☐ Login to the HealthPass Online Portal (HOP)

1. Enter www.healthpass.bswift.com in your browser
2. Enter your username and password

First time users:
Username: *First Initial of First Name, First 3 Letters of Last Name, Last 4 of SSN*
Example: John Smith (SSN: 000-00-1234) = JSMI1234
Password: *Date of Birth*
Example: John Smith (DOB 1/23/1991) = 01231991

You will be required to change your password after your initial login.

☐ Click "Continue Your Renewal Application"

Review your Company Information & Upload Documents → Review your Employee Information → Choose your Plan Offerings → Setup your Defined Contribution Strategy → Review your Bank Information

☐ Start your Open Enrollment

Select "Start an Open Enrollment window for employees", then select "Yes, Send an email notification".

☐ Customize and send your Open Enrollment Email

We recommend including an open enrollment end date to advise employees of the deadline to make plan selections. Select "Include Username", and "Save".

Your employees will receive your email announcing Open Enrollment and can now login to make their plan selections. Employee Open Enrollment instructions enclosed.

☐ End your Open Enrollment

Once all employees have made their plan selections navigate to Exchange Admin, then Group Manager. Select your group. Click "End Enrollment".

Once enrollment has ended employees cannot make changes to their plan selections. The HealthPass Team will review your submission and contact you if additional information is needed.

EMPLOYEE OPEN ENROLLMENT
SHOP & ENROLL IN YOUR BENEFITS ONLINE

Your employer is giving you a new and easier way to shop, enroll, and manage your healthcare benefits online.

- Compare plan options side by side
- Built-in decision support
- No more paper forms
- Manage your benefits from anywhere

IT'S EASY TO GET STARTED

- [ ] **Login to the HealthPass Online Portal (HOP)**
  1. Follow the link provided by your employer or enter www.healthpass.bswift.com in your browser, on your desktop or mobile device.
  2. Enter your username and password.

  First time users:
  Username: *First Initial of First Name, First 3 Letters of Last Name, Last 4 of SSN*
  Example: John Smith (SSN: 000-00-1234) = JSMI1234
  Password: *Date of Birth*
  Example: John Smith (DOB 1/23/1991) = 01231991

  You will be required to change your password after your initial login.

- [ ] **Click "Start Your Enrollment"**

- [ ] **Review your information and add family members, if applicable**
  Review and update your contact information. If you're adding family members for the first time, you'll need their SSN and date of birth.

- [ ] **Review your benefits options**
  Click "View Plan Options" for each benefit type. You can compare plans side by side, or click "Which Plan is Best for Me?" This gives you a personalized recommendation based on your healthcare spending.

- [ ] **Enroll in benefits**
  Select the family members you want covered (if any), then select the plan you want. Repeat and continue for each benefit type.

- [ ] **Save your enrollment**
  View, print, or email your confirmation statement and keep for your records.

HealthPass℠ BENEFITS EXCHANGE

Renewal Application

To make changes to your group policy, complete and submit this form to your broker or login to your HealthPass Online Portal (HOP) via www.healthpass.com. Quick and easy open enrollment instructions are available online in the Forms & Documents/Renewal Forms drop-down menu.

Full Name of Company | HealthPass Group # | COBRA - Federal or State:
❒Federal (Greater than 20 Employees)
❒State (Less than 20 Employees)

Organization Type:* ❒"C" Corp ❒"S" Corp ❒Partnership/LLP ❒Non-Profit ❒Sole Proprietorship ❒Church ❒Limited Liability Corporation

Employer Industry:*
❒Arts/Entertainment/Recreation ❒Construction/Utilities ❒Education
❒Finance/Insurance/Real Estate ❒Food/Hospitality ❒Healthcare/Social Assistance
❒Manufacturing ❒Print/Media ❒Professional/Technical Services
❒Retail ❒Transportation/Warehouse ❒Wholesale
❒Other

A. YOUR COMPANY

Indicate changes to your group policy in the fields below. Your policy will renew as is in the fields where you do not indicate a change.

Primary Contact Name | Primary Contact Phone Number/Ext. | Primary Contact Email

Street Address (No P.O. Boxes) | Suite | City/State/Zip

County or Borough | Fax Number

Billing Contact Name | Billing Contact Phone/Ext. | Billing Contact Email

Billing Street Address (if different) | Billing Suite | City/State/Zip

B. ELIGIBILITY AND ENROLLMENT

Number of Eligible Employees_____
Waiting period (Coverage Begins on the 1st of the Month Following) ❒0 Months ❒1 Month ❒2 Months
How many hours per week must employees work to be eligible for coverage?_____ (Must be between 20 and 40 hours)
Number of Enrollments with HealthPass_____
Number of Eligible Employees who have Other Health Coverage_____

Are you interested in offering FSA & Commuter Benefits to your employees? **(If no, skip to COBRA question.)** ❒Yes ❒No
Select Your Payroll Cycle (FSA & Commuter Benefits) ❒Weekly (52 Contributions) ❒Bi-Weekly (26 Contributions) ❒Semi-Monthly (24 Contributions) ❒Monthly (12 Contributions)
1st FSA Payroll Processing Date (MM/DD/YYY) ____/____/____

COBRA Administration Services? (included service): ❒ I would like to participate in COBRA Administration ❒ I would like to opt out of COBRA Administration

❒ **NYS-45 or applicable tax documents for the most recent quarter notating the number of hours worked per week for each employee if changing any of the following:**
- The number of hours worked per week to be eligible for coverage
- Enrolling in COBRA Administration
- Adding Dental Package 2 or 3 (unless switching between packages 2 and 3)
- Adding Vision Package 1 or 3 (unless switching between packages 1 and 3)

C. MEDICAL AND ANCILLARY PLAN OFFERINGS

Medical Plans

Indicate the medical plans you would like to offer or all medical plans will be made available.

Base Carrier Offerings: EmblemHealth, Healthfirst and Oxford (Metro only)

HealthPass Participation Requirements: 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 20% of the total eligible employees must enroll with a HealthPass medical plan.

To include Oxford – Liberty Plans

Liberty Participation Requirements: 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 60% of the total eligible employees, after valid waivers, must enroll in combination of Oxford – Liberty and/or Oxford – Metro plans.

EmblemHealth Plans			
❒Bridge Platinum PPO Renewal Only ❒Prime Platinum Premier	❒Bridge Gold PPO Renewal Only ❒Prime Gold Premier ❒Bridge Gold Virtual Renewal Only	❒Prime Silver Premier ❒Prime Silver HSA	❒Prime Bronze HSA ❒Prime Bronze Premier
Healthfirst Plans			
❒Platinum Pro EPO	❒Gold 1350 Pro Plus EPO	❒Silver Pro EPO ❒Silver 45/75/4300 Pro EPO	❒Bronze 6850 Pro EPO HSA
Oxford Metro Plans			
N/A	❒Metro Gold EPO 25/40 G ❒Metro Gold EPO 25/40	❒Metro Silver EPO 30/80 G ❒Metro Silver EPO 50/100 ZD	❒Metro Bronze HSA 7000 G
Oxford Liberty Plans			
To include Oxford – Liberty Plans, see above Liberty Participation Requirements. If the group does not meet the Oxford – Liberty Participation Requirements at open enrollment: the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Oxford – Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Oxford – Liberty enrollees will be mapped into Oxford – Metro plans within the same selected metal tier.			
❒Liberty Platinum EPO	❒Liberty Gold EPO 30/60 ❒Liberty Gold EPO 30/60 G ❒Liberty Gold EPO 25/50 ZD ❒Liberty Gold HSA 1500 M	❒Liberty Silver EPO 30/60 G ❒Liberty Silver EPO 40/80 ❒Liberty Silver EPO 50/100 ZD ❒Liberty Silver HSA 4000 M	❒Liberty Bronze HSA 5750

G = Gated, M = Motion, ZD = Zero Deductible

Dental Plans

Indicate a change to your dental offering here. If you do not indicate a change, your offering will renew as is.

Dental Options	**❒Package 1 (In-Network plans only):** Guardian Managed DentalGuard DHMO Guardian Managed DentalGuard DHMO *Plus* Solstice Dental EPO S700B Solstice Dental EPO S800B UnitedHealthcare Select Managed Care	**❒Package 2^:** Guardian Managed DentalGuard DHMO Guardian DentalGuard Preferred PPO MAC	**❒Package 3^:** Guardian Managed DentalGuard DHMO *Plus* Guardian DentalGuard Preferred PPO Plus MAC
❒Package 4: Solstice Dental EPO S700B Solstice Dental EPO S800B Solstice Dental PPO Solstice Dental Value PPO MAC	**❒Package 5^:** UnitedHealthcare Select Managed Care UnitedHealthcare Low PPO MAC UnitedHealthcare High PPO MAC	**❒Package 6^:** UnitedHealthcare INO 100/50/50 UnitedHealthcare High PPO MAC	**❒Package 7:** Not Interested

^Participation requirements apply.

Vision Plans

Indicate a change to your vision offering here. If you do not indicate a change, your offering will renew as is.

Vision Options	❒**Package 1^:** Guardian VisionGuard Solstice Vision PPO UnitedHealthcare Vision PPO	❒**Package 2:** Solstice Vision PPO UnitedHealthcare Vision PPO	❒**Package 3^:** Guardian VisionGuard
	❒**Package 4:** Solstice Vision PPO	❒**Package 5:** UnitedHealthcare Vision PPO	❒**Package 6:** Not Interested

^Participation requirements apply.

FSA & Commuter Benefits

Choose if you would like to offer FSA & Commuter Benefits to your employees for the upcoming policy year. If you choose not to offer FSA & Commuter Benefits at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer. Please note: every year your employees will have to re-establish their plans and amounts.

OCA FSA & Commuter Benefits: $8.00 PEPM (per enrolled per month) is billed directly to the employer by OCA for each enrolled employee. Only (1) fee is charged per employee even if enrolled in multiple plans.

Select any of the plans you wish to offer:

OCA FSA & Commuter Benefits
❒**Healthcare Flexible Spending Account (FSA)** Select Yearly Amount Plan: ❍ FSA $1000 Max ❍ FSA $2000 Max ❍ FSA $3050 IRS Max
❒**Dependent Care Account (DCA) FSA** Yearly Maximum Amount: $5000
❒**Parking Plan** Monthly Maximum Amount: $300
❒**Transit Plan** Monthly Maximum Amount: $300
❒Not Interested

An OCA representative will reach out to you directly to complete the enrollment in these plans

Life/AD&D/LTD Plans

Indicate a change to your Life/AD&D/LTD plan offering here. If you do not indicate a change, your offering will renew as is.

Guardian Plans	❒EverGuard	❒EverGuard *Plus*	❒Dual Option	❒Not Interested

Accident Plan

Indicate a change to your Accident plan offering here. If you do not indicate a change, your offering will renew as is.

Guardian Plan	❒AccidentGuard Adv	❒Not Interested

ID Theft Plans

Indicate a change to your ID Theft plan offering here. If you do not indicate a change, your offering will renew as is.

ID Theft Plans	❒**Allstate Identity Protection**	❒**LifeLock**	❒**Not Interested**
	❍Allstate Identity Protection	❍Benefit Elite	
	❍Allstate Identity Protection Pro Plus	❍Ultimate Plus	

Pet Plan

Choose if you would like to offer a Pet Plan to your employees for the upcoming policy year. If you choose not to offer a Pet Plan at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer.

Pet Plan	❒Total Pet Plan	❒Not Interested

This is a discount plan bundle from Pet Benefit Solutions and includes Pet Assure, Pet Plus, AskVet and The PetTag (not insurance).

For more valued HealthPass Products & Services, such as a POP Kit Section 125 and Beyond Med, visit https://healthpass.com/extra-products-and-services/ to find out more and enroll.

Defined Contribution

Determine how to apply your monthly contributions:

- ❒ **No Contribution**
- ❒ **Lump Sum $**_____ Additional funds will rollover into any selected ancillary plans.
- ❒ **Contribute Per Plan Type (by percent or flat dollar):**
  - Medical _____
  - Dental _____
  - Vision _____
- ❒ **Contribute by Coverage Tier (by percent or flat dollar):**

Medical	EE Only_____	EE/Sp_____	EE Child(ren)_____	Family_____
Dental	EE Only_____	EE/Sp_____	EE Child(ren)_____	Family_____
Vision	EE Only_____	EE/Sp_____	EE Child(ren)_____	Family_____

D. BANK INFORMATION

How do you prefer to pay for your coverage? (Select One)

❒ Please use electronic funds transfer (EFT) for my monthly payment.* (Must attach a voided business check)
❒ Please bill me monthly.

❒ I would like to enroll in paperless billing. If enrolling in paperless billing we must have an active email address on file.

If EFT is selected, I hereby authorize HealthPass to initiate electronic funds transfer (EFT) from my account for the payment of my monthly cost of coverage. I understand the debit transaction will occur the 1st of the month or the 1st business day following. In the event that I make changes to my banking arrangements, I understand that I must notify HealthPass to effect the changes for payment collection. All changes must be reported 20 days prior to the effective date of the change by calling HealthPass at 888-313-7277.

*The HealthPass Merchant ID is 131575. Check with your financial institution as you may need to provide this ID in order for payments to be processed successfully.

E. EMPLOYER CERTIFICATION

I agree and attest that:

- ❒ My business offers HealthPass medical coverage to every eligible full-time employee and age, sex or health status cannot be used to determine employee eligibility.
- ❒ An eligible employee must be defined as one that works no less than 20 hours per week and my business must have at least one (1) such eligible employee.
- ❒ Part-time employees (working less than 20 hours per week), temporary employees, employees working outside of the US, household help, and retirees are not eligible for coverage through HealthPass. Other exclusions may apply.
- ❒ The group meets HealthPass participation requirements:
  - Base carrier offerings: EmblemHealth, Healthfirst and Oxford (Metro only)
    HealthPass Participation Requirements: 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 20% of the total eligible employees must enroll with a HealthPass medical plan.
  - To include Oxford – Liberty Plans
    Liberty Participation Requirements: 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 60% of the total eligible employees, after valid waivers, must enroll in a combination of Oxford – Liberty and/or Oxford – Metro plans.
- ❒ The group meets all HealthPass carrier out-of-area coverage requirements
  - **EmblemHealth**
    Bridge Plans - Employees can reside in any of the 50 US states. Bridge Program includes: Prime, GHI National, Connecticare, QualCare and First Health networks.
    Prime Plans - Employees must live/work/reside in NY, NJ and CT.
  - **Healthfirst**
    Pro Plans - Employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland.
  - **Oxford**
    Metro Plans - Employees must live/work in NY and NJ.
    Liberty Non-Gated Plans - Employees can live anywhere in the continental US.
    Liberty Gated (G) Plans - Employees must live in NY, NJ and CT. These members have access to Choice Plus when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).
- ❒ This application has been completed with accurate information and in no way has any information been misrepresented, falsely provided, or reinforced by false documentation that has been presented. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or state department of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material here to, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed $5,000 and the stated value of the claim for each such violation plus the amount of the claim on individuals who commit fraudulent insurance acts. Additionally, the State has the right to levy a civil fine of up to $1,000 for possession of a fraudulent health insurance identification card and up to $5,000 for each addition card possessed.

Please refer to our Eligibility Guidelines for more detailed information.

F. PROGRAM BENEFITS

Health Advocacy: All members with medical coverage through HealthPass (excluding COBRA enrollees) have access to Health Advocate™ to assist with navigating many healthcare related issues, including support in understanding claims and accessing providers.

HealthPass COBRA Administration Services: All groups have access to COBRA/NYSC Administration Services unless opted out by Employer in Section B. The service includes notification of former employees of their rights upon termination and the collection of payments from employees who elect to continue their coverage with their former employer. Employer understands it is responsible to timely and accurately perform all of their responsibilities by providing participant information. HealthPass COBRA Administration Services will terminate if (i) mandatory termination occurs due to non-payment or Employer otherwise ceases to offer medical insurance via HealthPass; (ii) Employer does not comply with the information or; (iii) Employer elects to cease to offer HealthPass COBRA Administration Services by declining such services in Section B of this form or otherwise in writing at any time. Employer agrees to indemnify HealthPass and all personnel involved in the provision of COBRA Administration Services.

G. FEE DISCLOSURE

Program Fees: All medical rates include $5.95 for HealthPass Program Benefits (non-carrier/agent services) and a 2.9% billing and administrative fee.

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard and EverGuard *Plus* plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50

H. HEALTHPASS INSURANCE TRUST

The undersigned employer, in order to establish a plan or plans of Group Health Insurance for its employees and their dependents, hereby requests participation in the New York Health Purchasing Alliance, Inc. and/or HealthPass Insurance Trust (the "Trust") which provides health insurance benefits under Group Contracts issued by several health insurers and health maintenance organizations (HMO) to the Trustee of the HealthPass Insurance Trust. If the undersigned employer's participation is approved by the Trustee or the Administrator appointed by the Trustee (the "Administrator"), said employer shall become a Participating Employer (as defined in Trust Agreement) as of the effective date endorsed herein by the Trustee or the Administrator.
The undersigned employer understands and acknowledges that even if it is approved as a Participating Employer in the HealthPass Insurance Trust, employees and their dependents are not automatically insured, as each must satisfy any eligibility requirements of the Trust and of the applicable Group Contracts. The Participating Employer agrees to make the coverage under Group Contracts available to all of its current and future eligible employees.

The undersigned employer hereby agrees:

- To be bound by all the terms of the Trust Agreement and of the Group Contract(s) as each may be from time to time amended, changed or terminated by the Insurer, HMO or Trustee, copies of which are available from the Trust or the Administrator upon request.
- To furnish any information requested by the Trustee, Administrator or any of the Insurers or HMOs, which is reasonably required for the proper administration of the Trust or of the Group Contract.
- To distribute to its eligible employees any materials provided by or on behalf of the Trustee, Administrator, Health Insurer or HMO describing Trust or the Group Contract.
- That it has no right, title or interest in or to the Trust Fund created under Trust.
- Coverage under any Contract through the Trust shall only apply to the extent provided in the Group Contract issued to the Trust by the insurer or HMO. All claims for benefits must be submitted to the insurer or HMO. Benefits are payable only by the insurer or HMO. The Trust's responsibility is solely to pay premiums to the insurer or HMO. The Trust is not liable for any benefit payments.
- The Trustee does not have any obligation under any of the Group Contracts to automatically insure employer groups should HealthPass not be in receipt of payment by the end of the month of the date due. Full payment must be made to keep all group policies active.

All enrollment documentation must be fully complete and submitted by the 20th of the month prior for effective coverage for the 1st of the following month. Any enrollment documentation received after the 20th of the month will subject the entire group to delays in coverage activation up to 10-12 business days.

Company Name _____ **Group Number** _____

Print Name _____ **Date** _____

Authorized Signature _____ **Title** _____

Happy to help.
For assistance contact the HealthPass Retention Department at 888-313-7277 or email renewals@healthpass.com.

HealthPass BENEFITS EXCHANGE

Renewing Group Attestation Form

I attest that my business is not taking the following actions at renewal:

- Changing the number of hours worked per week to be eligible for coverage
- Enrolling in COBRA Administration
- Adding Dental Package 2 or 3 (unless switching between packages 2 and 3)
- Adding Vision Package 1 or 3 (unless switching between packages 1 and 3)

I understand that if my business has changes to any of the above group criteria, we will be required to provide proof of continued eligibility. Failure to produce the required proof of continued eligibility may result in termination of group coverage. HealthPass and its partner carriers reserve the right to request documentation to ensure continued eligibility at any time.

Group Name/Group Number_____

Authorized Signature_____ Date_____

Print Name_____ Date_____

Please sign and return this attestation form along with your employee enrollment changes to your broker or step through your renewal online and upload it to your renewal application.

Client Retention Department
888-313-7277
renewals@healthpass.com

HealthPass BENEFITS EXCHANGE

2023 ENROLLMENT/CHANGE FORM

www.healthpass.com | P 888-313-7277

Employee Name: **Group Name/Group #:**

A. Enrollments/Additions - Complete A, E, F, Q, R and select coverages G – P

Requested Effective Date (Other than birth or adoption, all coverage effective dates are the 1st of the month following the qualifying event):

_____/_____/_____

Reason (Select one):

❒Open Enrollment/Renewal
❒Add Dependent
❒Date of Birth _____/_____/_____
❒Date of Marriage _____/_____/_____
❒New Hire
❒Rehire
❒Status Change (part-time to full-time) _____/_____/_____
❒Adoption (requires legal documentation)
❒Involuntary Loss of Coverage
❒Other_____

The following documents are required and must be submitted within 30 days of an associated qualifying event:
HIPAA Certificate or Carrier Termination Letter if enrolling due to loss of coverage; Marriage Certificate if enrolling a spouse due to a qualifying event; Birth Certificate if adding a newborn to the policy outside 30 days of the qualifying event (DOB); Declaration of Cohabitation & Financial Interdependence Form if enrolling a domestic partner due to a qualifying event. Note: Additional documentation may be required.

B. Waive Coverage - Complete B, E, Q, R

Requested Effective Date
(1st of the month only)

_____/_____/_____

Waive coverages:
❒Medical
❒Dental
❒Vision

Reason for Waiving:

Valid Waiver:
❒Spousal Coverage
❒Medicare
❒Medicaid
❒Veteran's Administration
❒Parental Waiver

Invalid Waiver:
❒Employer Sponsored Coverage
❒Individual Coverage
❒Exchange Coverage

C. Change Requests - Complete C, Q, R and list changes in E, F

Requested Effective Date:

_____/_____/_____

Change Type:
❒Name Change ❒Address Change ❒Other_____

D. Terminations - Complete D, E, F, Q, R. Termination date must be the last day of the month.

Requested Effective Date:

_____/_____/_____

Reason:
❒No Longer Employed ❒Cancel Coverage ❒ Other_____

❒Medical
❒Employee
❒Spouse
❒Child(ren)

❒Dental
❒Employee
❒Spouse
❒Child(ren)

❒Vision
❒Employee
❒Spouse
❒Child(ren)

❒FSA & Commuter Benefits
❒Healthcare Flexible Spending Account (FSA)
❒Dependent Care Account (DCA) FSA
❒Parking Plan
❒Transit Plan

❒Life/AD&D/LTD
❒EverGuard
❒EverGuard *Plus*

❒Accident
❒Employee
❒Spouse
❒Child(ren)

❒ID Theft
❒Employee
❒Spouse
❒Child(ren)

❒Pet Plan
❒Single Pet
❒Family Pet

Indicate the coverage(s) and member(s) to terminate above. Select Child(ren) - If terminating coverage for one or more child(ren) on the policy (but not all) then list in Section F those who should have their coverage terminated. **NOTE** - If no child(ren) are separately listed in Section F, ALL dependent children on the policy will be terminated.

E. Employee Information

Group Name | Hire Date* (MM/DD/YYYY)

Prefix | First Name* | Middle Initial | Last Name* | Suffix | Social Security #*

Date of Birth* (MM/DD/YYYY) _____/_____/_____

Gender*: ❒Male ❒Female

Marital Status: ❒Divorced ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒Widowed

Address* | Apt | City/State/Zip* | County

Home Phone/Cell Phone | Work Phone*

Email*

F. Dependent Demographics

Dependent 1

Prefix | First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Social Security #*

Gender*: ❒ Male ❒Female

Disabled? (Requires Additional Documents) ❒Yes ❒No

Marital Status: ❒Divorced ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒Widowed

Relationship*: ❒Spouse ❒Domestic Partner ❒Child ❒Domestic Partner Child

Dependent 2

Prefix | First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Social Security #*

Gender*: ❒ Male ❒Female

Disabled? (Requires Additional Documents) ❒Yes ❒No

Marital Status: ❒Divorced ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒Widowed

Relationship*: ❒Spouse ❒Domestic Partner ❒Child ❒Domestic Partner Child

Dependent 3

Prefix | First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) _____/_____/_____ | Social Security #*

Gender*: ❒ Male ❒Female

Disabled? (Requires Additional Documents) ❒Yes ❒No

Marital Status: ❒Divorced ❒Legally Separated ❒Single ❒Domestic Partner ❒Married ❒Widowed

Relationship*: ❒Spouse ❒Domestic Partner ❒Child ❒Domestic Partner Child

Employee Name: **Group Name/Group #:**

G. Medical (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

EmblemHealth

EmblemHealth Plans - To enroll in Bridge plans employees can reside in any of the 50 US states. Bridge Program includes: Prime, GHI National, Connecticare, QualCare and First Health networks.
To enroll in Prime plans employees must live/work/reside in NY, NJ and CT.

❒Bridge Platinum PPO Renewal Only ❒Prime Platinum Premier	❒Bridge Gold PPO Renewal Only ❒Prime Gold Premier ❒Bridge Gold Virtual Renewal Only	❒Prime Silver Premier ❒Prime Silver HSA	❒Prime Bronze HSA ❒Prime Bronze Premier

healthfirst Health Insurance for New Yorkers

Healthfirst Plans - To enroll in Pro plans employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland

❒Platinum Pro EPO	❒Gold 1350 Pro Plus EPO	❒Silver Pro EPO ❒Silver 45/75/4300 Pro EPO	❒Bronze 6850 Pro EPO HSA

United Healthcare Oxford

Oxford Metro Plans - To enroll in Metro plans employees must live/work in NY and NJ.

N/A	❒Metro Gold EPO 25/40 G ❒Metro Gold EPO 25/40	❒Metro Silver EPO 30/80 G ❒Metro Silver EPO 50/100 ZD	❒Metro Bronze HSA 7000 G

United Healthcare Oxford

Oxford Liberty Plans - If the group does not meet the Oxford – Liberty Participation Requirements at open enrollment: the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Oxford – Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Oxford – Liberty enrollees will be mapped into Oxford – Metro plans within the same selected metal tier.

To enroll in Liberty non-gated plans employees can live anywhere in the continental US.

To enroll in Liberty gated (G) plans employees must live in NY, NJ and CT. These members have access to Core Network when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).

❒Liberty Platinum EPO	❒Liberty Gold EPO 30/60 ❒Liberty Gold EPO 30/60 G ❒Liberty Gold EPO 25/50 ZD ❒Liberty Gold HSA 1500 M	❒Liberty Silver EPO 30/60 G ❒Liberty Silver EPO 40/80 ❒Liberty Silver EPO 50/100 ZD ❒Liberty Silver HSA 4000 M	❒Liberty Bronze HSA 5750

G = Gated, M = Motion, ZD = Zero Deductible

H. PCP Selection

NOTE If enrolling in an EmblemHealth, Healthfirst or Oxford G (gated) medical plan for the first time, you must select a primary care physician (PCP) by writing the Primary Physician ID # below. **IMPORTANT:** write the exact PCP # for proper assignment. If you do not have a PCP at the moment, write 4 zeros (0000) in the field. Do NOT write a symbol/letter/space/doctor name/character or less than 4 numeric digits as those will cause enrollment issues. If you do not write a true PCP # one will be assigned to you by the carrier. To change a PCP after initial enrollment, you must contact the carrier directly.

Employee# _____ Dependent 2# _____

Dependent 1# _____ Dependent 3# _____

I. Dental (Select one plan)

Coverage for (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Guardian	❒Managed DentalGuard DHMO**	❒Managed DentalGuard DHMO *Plus***
	❒DentalGuard Preferred PPO MAC	❒DentalGuard Preferred PPO *Plus* MAC
Solstice	❒Dental EPO S700B	❒Dental EPO S800B
	❒Dental PPO	❒Dental Value PPO MAC
UnitedHealthcare	❒Select Managed Care	❒INO 100/50/50
	❒Low PPO MAC	❒High PPO MAC

Employee Name: **Group Name/Group #:**

J. Dental Facility**

NOTE If enrolling in a Guardian DHMO dental plan for the first time, you must select a primary care dentist (PCD) by writing the Primary Dentist ID # below. **IMPORTANT:** write the exact PCD # for proper assignment. If you do not have a PCD at the moment, write 4 zeros (0000) in the field. Do NOT write a symbol/letter/space/doctor name/character or less than 4 numeric digits as those will cause enrollment issues. If you do not write a true PCD # one will be assigned to you by the carrier. To change a PCD after initial enrollment, you must contact the carrier directly

Employee _____ Dependent #1_____ Dependent #2_____ Dependent #3_____

K. Vision

Coverage for (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

Coverage type (Select one): ❒Guardian VisionGuard ❒Solstice Vision PPO ❒UnitedHealthcare Vision PPO

L. FSA & Commuter Benefits

Select any of the plans you wish to enroll in and your amount(s):
Please note: every year you will have to re-establish your plans and amounts.

❒**Healthcare Flexible Spending Account (FSA)** **Yearly Amount: $** _____
(Confirm with your employer which plan your group offers: FSA $1000 Max, FSA $2000 Max, FSA $3050 IRS Max)

❒**Dependent Care Account (DCA) FSA** **Yearly Amount: $** _____ ($5000 IRS Max)

❒**Parking Plan** **Monthly Amount: $** _____ ($300 Max)

❒**Transit Plan** **Monthly Amount: $** _____ ($300 Max)

Please process any mid-year OCA enrollments, changes and terminations through the HealthPass Online Portal (HOP).

M. Life/AD&D/LTD

Coverage type (Select one): ❒EverGuard ❒EverGuard *Plus*

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%):

Beneficiary Name 1*	Relation*	Percent*
Beneficiary Name 2*	Relation*	Percent*

N. Accident

Coverage type (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family

❒Guardian AccidentGuard Adv *To enroll in the Guardian Accident Plan: comprehensive hospital, surgical and medical insurance is required on the effective date of this application for all enrollees.*

Beneficiary Name 1*	Relation*	Percent*
Beneficiary Name 2*	Relation*	Percent*

O. ID Theft

Allstate Identity Protection
Coverage for (Select one): ❒Employee Only ❒Family
Coverage type (Select one): ❒Allstate Identity Protection Pro ❒Allstate Identity Protection Pro Plus

LifeLock
Coverage for (Select one): ❒Employee Only ❒Employee/Spouse ❒Employee/Child(ren) ❒Family
Coverage type (Select one): ❒Benefit Elite ❒Ultimate Plus ™

A phone number is required when enrolling in either plan.

P. Pet

Total Pet Plan Coverage type (Select one): ❒Single Pet Plan ❒Family Pet Plan (2+)

This is a discount plan bundle from Pet Benefit Solutions and includes Pet Assure, Pet Plus, AskVet and The PetTag (not insurance).

Employee Name: **Group Name/Group #:**

Q. Employee Signature

I hereby apply for the health insurance company and benefit plans selected, understanding all benefits and coverage as specified in the enrollment materials and agreeing to abide by all the rules and regulations therein specified. I certify that I am actively at work a minimum of 20 hours per week and will notify HealthPass if my employment status changes. I elect to enroll myself and any family members indicated on this form with the benefit plans and primary care provider as indicated on this form. I certify that all dependents listed on this form are eligible for coverage under the terms of the plan documents. I agree to notify my employer within 30 days when such eligibility ceases. I understand the plans have no liability to provide coverage for ineligible dependents. On behalf of myself and all family members, I hereby authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by the health insurance company, provided any diagnosis, treatment or any other service to any of us, to furnish the insurance companies or their authorized representative all information and records relating thereto. A photocopy or digital image of this authorization shall be considered as valid as the original. I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the other applicable coverage ends. (See HealthPass' Eligibility Guidelines). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoptions, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If I am required to contribute premium toward my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due to me and remit the same to HealthPass. I understand that the subscriber is responsible for the total cost of care received and/or for drugs purchased which are not authorized by the plan. "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation". I am aware the NYHPA/dba HealthPass privacy practices is posted for my review and can be found on www.healthpass.com. I have carefully read this section and certify that all information provided on this form is true and complete to the best of my knowledge.

Employee Signature: X_____ Date: X_____

R. Authorized Signature

I certify that the person(s) presented on this form are eligible employees or dependents and the employee works for the employer identified on this form. This form and all other enrollment documentation submitted by the employer, or its duly authorized officer, must be fully complete and transacted by the 20th of the month prior for effective coverage for the 1st of the following month. Any documentation received after the 20th of the month will result in delays in enrollment up to 10-12 business days.

Authorized Signature: X_____ Date: X_____

S. Extra Products & Services

To enroll in Beyond Med, a membership program that elevates health and well-being by providing access to a proprietary network of board-certified doctors and licensed providers at reduced rates on elective and cosmetic services, visit https://beyondmedplans.com/healthpass/

For more valued HealthPass Products & Services visit https://healthpass.com/extra-products-and-services/ to find out more and enroll.

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2023, 2/1/2023, 3/1/2023

Dental

Dental Package 1 - All Carriers (In-Network plans only) Guardian Managed DentalGuard DHMO, Guardian Managed DentalGuard DHMO *Plus*, Solstice Dental EPO S700B, Solstice Dental EPO S800B and UnitedHealthcare Select Managed Care. There is no minimum participation.

Guardian Managed DentalGuard DHMO

- $5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- No annual maximum on the plan and offers fixed patient charges for basic and major services
- No deductible
- Orthodontia benefit

	Four Tier
Employee	$17.85
Emp/Spouse	$35.07
Emp/Child(ren)	$36.22
Family	$53.32

Guardian Managed DentalGuard DHMO *Plus*

- $5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- No annual maximum, the *Plus* plan offers a lower fixed patient charges for basic and major services than the standard DHMO plan
- No deductible
- Orthodontia benefit

	Four Tier
Employee	$20.81
Emp/Spouse	$40.86
Emp/Child(ren)	$44.68
Family	$64.74

Solstice Dental EPO S700B

- $0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- Open access and no specialist referrals
- No deductible, no calendar year maximum
- Cosmetic and orthodontia treatment covered
- Implant benefit via implant network provider only

	Four Tier
Employee	$17.37
Emp/Spouse	$33.99
Emp/Child(ren)	$38.32
Family	$53.50

Solstice Dental EPO S800B

- $0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- Open access and no specialist referrals
- No deductible, no calendar year maximum
- Cosmetic and orthodontia treatment covered
- Implant benefit via implant network provider only

	Four Tier
Employee	$13.56
Emp/Spouse	$26.36
Emp/Child(ren)	$29.65
Family	$41.36

UnitedHealthcare Select Managed Care

- 1 cleaning per consecutive 6 months
- No deductible
- No annual calendar maximum
- No waiting period
- Reasonable copayment charges apply for basic and major services
- Implant benefit

	Four Tier
Employee	$17.66
Emp/Spouse	$30.61
Emp/Child(ren)	$37.27
Family	$47.52

Dental Package 2 - Guardian Managed DentalGuard DHMO and Guardian DentalGuard Preferred PPO MAC. There is 75% participation, excluding dental waivers.

Guardian Managed DentalGuard DHMO

- $5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- No annual maximum on the plan and offers fixed patient charges for basic and major services
- No deductible
- Orthodontia benefit

	Four Tier
Employee	$17.85
Emp/Spouse	$35.07
Emp/Child(ren)	$36.22
Family	$53.32

Guardian DentalGuard Preferred PPO MAC

- No referrals needed to see a specialist
- Out-of-area emergency coverage
- $50 deductible for In-Network services/$75 deductible for Out-of-Network services
- Annual maximum of $1,000 In-Network-rollover
- Implant benefit

	Four Tier
Employee	$45.86
Emp/Spouse	$96.37
Emp/Child(ren)	$87.86
Family	$140.40

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard & EverGuard Plus plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2023, 2/1/2023, 3/1/2023

Dental continued…

Dental Package 3 - Guardian Managed DentalGuard DHMO *Plus* and Guardian DentalGuard Preferred PPO *Plus* MAC. There is 75% participation, excluding dental waivers.

Guardian Managed DentalGuard DHMO *Plus*

- $5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- No annual maximum, the *Plus* plan offers a lower fixed patient charges for basic and major services than the standard DMO plan
- No deductible
- Orthodontia benefit

	Four Tier
Employee	$20.81
Emp/Spouse	$40.86
Emp/Child(ren)	$44.68
Family	$64.74

Guardian DentalGuard Preferred PPO *Plus* MAC

- No referrals are needed to see a specialist
- Out-of-area emergency coverage
- $50 deductible for In-Network services/$50 deductible for Out-of-Network services
- Combined In-Network and Out-of-Network annual maximum of $1,000 with an additional $500 of benefit In-Network (In-Network rollover)
- Implant benefit

	Four Tier
Employee	$52.45
Emp/Spouse	$110.44
Emp/Child(ren)	$100.71
Family	$160.90

Dental Package 4 - Solstice Dental EPO S700B, Solstice Dental EPO S800B, Solstice Dental PPO and Solstice Dental Value PPO MAC. There is no minimum participation.

Solstice Dental EPO S700B

- $0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- Open access and no specialist referrals
- No deductible, no calendar year maximum
- Cosmetic and orthodontia treatment covered
- Implant benefit via implant network provider only

	Four Tier
Employee	$17.37
Emp/Spouse	$33.99
Emp/Child(ren)	$38.32
Family	$53.50

Solstice Dental EPO S800B

- $0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only)
- Open access and no specialist referrals
- No deductible, no calendar year maximum
- Cosmetic and orthodontia treatment covered
- Implant benefit via implant network provider only

	Four Tier
Employee	$13.56
Emp/Spouse	$26.36
Emp/Child(ren)	$29.65
Family	$41.36

Solstice Dental PPO

- Includes 4 cleanings in any 12 consecutive months
- No referrals needed to see a specialist
- $50 deductible for In-Network services/$50 deductible for Out-of-Network services
- Annual maximum of $2,000
- Implant benefit

	Four Tier
Employee	$58.90
Emp/Spouse	$105.14
Emp/Child(ren)	$124.07
Family	$163.04

Solstice Dental Value PPO MAC

- Includes 2 cleanings in any 12 consecutive months
- No referrals needed to see a specialist
- Out-of-Network reimbursement is MAC (Maximum Allowable Charge)
- $50 deductible for In-Network services/$50 deductible for Out-of-Network services
- Annual maximum of $1,000

	Four Tier
Employee	$34.25
Emp/Spouse	$68.24
Emp/Child(ren)	$73.31
Family	$106.03

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard & EverGuard Plus plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2023, 2/1/2023, 3/1/2023

Dental continued…

Dental Package 5 - UnitedHealthcare Select Managed Care, UnitedHealthcare Low PPO MAC and UnitedHealthcare High PPO MAC. There is a two enrolled minimum participation.

UnitedHealthcare Select Managed Care		Four Tier
• 1 cleaning per consecutive 6 months • No deductible • No annual calendar maximum • No waiting period • Reasonable copayment charges apply for basic and major services • Implant benefit	**Employee**	**$17.66**
	Emp/Spouse	**$30.61**
	Emp/Child(ren)	**$37.27**
	Family	**$47.52**

UnitedHealthcare Low PPO MAC		Four Tier
• No referrals to see a specialist • $50 deductible /$75 deductible family (calendar year) • $1,000 both In and Out-of-Network annual maximum • Out-of-Network reimbursement is MAC (Maximum Allowable Charge) which is based on participating provider contracted fees • Implant and orthodontic benefits • Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum	**Employee**	**$45.35**
	Emp/Spouse	**$90.46**
	Emp/Child(ren)	**$91.13**
	Family	**$142.37**

UnitedHealthcare High PPO MAC		Four Tier
• No referrals to see a specialist • Preventive and diagnostic care like exams, cleanings and x-rays won't apply to the annual maximum • $50 deductible /$100 deductible family (calendar year) • $2,000 both In and Out-of-Network annual maximum • Out-of-Network reimbursement is MAC (Maximum Allowable Charge) which is based on participating provider contracted fees • Implant and orthodontic benefits • Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum	**Employee**	**$53.23**
	Emp/Spouse	**$106.21**
	Emp/Child(ren)	**$104.84**
	Family	**$164.73**

Dental Package 6 - UnitedHealthcare INO 100/50/50 and UnitedHealthcare High PPO MAC. There is a two enrolled minimum participation.

UnitedHealthcare INO 100/50/50		Four Tier
• 2 cleanings per consecutive 12 months • No referrals to see a specialist • No waiting period • $50 deductible /$150 deductible family (calendar year) • $1,000 annual maximum • Includes Out-of-Network emergency treatment, if necessary • Implant and orthodontic benefits • Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum	**Employee**	**$26.49**
	Emp/Spouse	**$52.23**
	Emp/Child(ren)	**$54.90**
	Family	**$84.32**

UnitedHealthcare High PPO MAC		Four Tier
• No referrals to see a specialist • Preventive and diagnostic care like exams, cleanings and x-rays won't apply to the annual maximum • $50 deductible /$100 deductible family (calendar year) • $2,000 both In and Out-of-Network annual maximum • Out-of-Network reimbursement is MAC (Maximum Allowable Charge) which is based on participating provider contracted fees • Implant and orthodontic benefits • Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum	**Employee**	**$53.23**
	Emp/Spouse	**$106.21**
	Emp/Child(ren)	**$104.84**
	Family	**$164.73**

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard & EverGuard Plus plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2023, 2/1/2023, 3/1/2023

Vision

Vision Package 1 – Guardian VisionGuard, Solstice Vision PPO and UnitedHealthcare Vision PPO. There is a 20% participation with Guardian VisionGuard, excluding vision waivers.

Guardian VisionGuard		Four Tier
• $10 copay for an exam every 12 months • $25 copay for materials every 24 months • Davis Vision In-Network and Out-of-Network access as well	**Employee**	**$6.93**
	Emp/Spouse	**$11.37**
	Emp/Child(ren)	**$11.55**
	Family	**$17.73**

Solstice Vision PPO		Four Tier
• $10 copay for an exam every 12 months • $25 copay for lenses & contact lenses every 12 months • $25 copay for frames every 24 months • Davis Vision In-Network; Out-of-Network access as well	**Employee**	**$7.72**
	Emp/Spouse	**$13.14**
	Emp/Child(ren)	**$15.75**
	Family	**$20.11**

UnitedHealthcare Vision PPO		Four Tier
• $10 copay for an exam every 12 months • $25 copay for materials every 12 months • Spectra Eyecare Networks; Out-of-Network access as well	**Employee**	**$6.69**
	Emp/Spouse	**$12.09**
	Emp/Child(ren)	**$13.79**
	Family	**$19.23**

Vision Package 2 – Solstice Vision PPO and UnitedHealthcare Vision PPO. There is no minimum participation.

Solstice Vision PPO		Four Tier
• $10 copay for an exam every 12 months • $25 copay for lenses & contact lenses every 12 months • $25 copay for frames every 24 months • Davis Vision In-Network; Out-of-Network access as well	**Employee**	**$7.72**
	Emp/Spouse	**$13.14**
	Emp/Child(ren)	**$15.75**
	Family	**$20.11**

UnitedHealthcare Vision PPO		Four Tier
• $10 copay for an exam every 12 months • $25 copay for materials every 12 months • Spectra Eyecare Networks; Out-of-Network access as well	**Employee**	**$6.69**
	Emp/Spouse	**$12.09**
	Emp/Child(ren)	**$13.79**
	Family	**$19.23**

Vision Package 3 – Guardian VisionGuard 20% participation, excluding vision waivers

Guardian VisionGuard		Four Tier
• $10 copay for an exam every 12 months • $25 copay for materials every 24 months • Davis Vision In-Network and Out-of-Network access as well	**Employee**	**$6.93**
	Emp/Spouse	**$11.37**
	Emp/Child(ren)	**$11.55**
	Family	**$17.73**

Vision Package 4 – Solstice Vision PPO no minimum participation

Solstice Vision PPO		Four Tier
• $10 copay for an exam every 12 months • $25 copay for lenses & contact lenses every 12 months • $25 copay for frames every 24 months • Davis Vision In-Network; Out-of-Network access as well	**Employee**	**$7.72**
	Emp/Spouse	**$13.14**
	Emp/Child(ren)	**$15.75**
	Family	**$20.11**

Vision Package 5 - UnitedHealthcare Vision PPO no minimum participation

UnitedHealthcare Vision PPO		Four Tier
• $10 copay for an exam every 12 months • $25 copay for materials every 12 months • Spectra Eyecare Networks; Out-of-Network access as well	**Employee**	**$6.69**
	Emp/Spouse	**$12.09**
	Emp/Child(ren)	**$13.79**
	Family	**$19.23**

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard & EverGuard Plus plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2023, 2/1/2023, 3/1/2023

FSA & Commuter Benefits

OCA - No minimum participation		
• Flexible Spending Account (FSA) - Employees set aside money to pay for qualified medical, dental & vision expenses on a pre-tax basis • Dependent Care Account (DCA) - Employees set aside money to pay for qualified dependent care expenses on a pre-tax basis • Parking & Transit - Employees set aside money to pay for qualified parking & transit expenses on a pre-tax basis	**Per Enrolled Per Month (PEPM)**	**$8.00**

Bundled Life & Disability

EverGuard - No minimum participation	Employee Ages	Three Tier
• $25,000 of Term Life Insurance • $75,000 of Accidental Death & Dismemberment Insurance • $1,000 per month of Disability Income • Guaranteed Issued	**18-39**	**$13.50**
	40-54	**$26.00**
	55+	**$48.50**

EverGuard *Plus* - No minimum participation	Employee Ages	Three Tier
• $50,000 of Term Life Insurance • $100,000 of Accidental Death & Dismemberment Insurance • $1,500 per month of Disability Income • Guaranteed Issued	**18-39**	**$21.50**
	40-54	**$39.50**
	55+	**$75.50**

Accident

Guardian AccidentGuard Adv - No minimum participation		Four Tier
• Emergency room and urgent care facility treatment • Hospital admission and confinement as well as ICU • Occupational or physical therapy • Transportation such as ambulance and air ambulance • Xrays • Household expenses towards rent, mortgage and/or food • Injury-related modifications to your home and/or auto	**Employee**	**$14.83**
	Emp/Spouse	**$23.63**
	Emp/Child(ren)	**$23.81**
	Family	**$33.61**

ID Theft

Allstate Identity Protection Pro - No minimum participation		Two Tier
• Identity and credit monitoring • Financial transaction monitoring • Social Media reputation monitoring • 24/7 Privacy Advocate remediation • $1 million identity theft insurance policy	**Employee**	**$7.95**
	Emp/Spouse	**n/a**
	Emp/Child(ren)	**n/a**
	Family	**$13.95**

Allstate Identity Protection Pro Plus - No minimum participation		Two Tier
• Includes all the benefits of the Allstate Identity Protection Pro plan with added features • Tri-bureau credit alerts and unlimited credit reports from TransUnion • In-app Credit Lock • IP address Monitoring • 401(k) and HSA stolen fund reimbursement • Tax fraud refund advances	**Employee**	**$9.95**
	Emp/Spouse	**n/a**
	Emp/Child(ren)	**n/a**
	Family	**$17.95**

LifeLock Benefit Elite - No minimum participation		Four Tier
• LifeLock Identity Alert System • Lost Wallet Protection • Address Change Verification • Black Market Website Surveillance • Checking and Savings Account Activity Alerts • Stolen Fund Reimbursement: Up to $1 Million	**Employee**	**$7.74**
	Emp/Spouse	**$15.48**
	Emp/Child(ren)	**$13.55**
	Family	**$21.30**

LifeLock Ultimate Plus™ - No minimum participation		Four Tier
• Ultimate Plus™ plan includes all of the Benefit Elite plan with added features • Checking & Savings Account Application Alerts • Bank Account Takeover Alerts • Online Annual tri-bureau credit reports & scores • Monthly Credit Score Tracking • Sex Offender Registry Reports	**Employee**	**$23.24**
	Emp/Spouse	**$46.48**
	Emp/Child(ren)	**$32.93**
	Family	**$56.17**

Pet Benefit Solutions

Total Pet Plan (discount plan bundle) - No minimum participation		Two Tier
• Pet Assure (any type of pet) - 25% discount from participating vets in US and PR, applies to all in-house medical services • PetPlus (dogs & cats only) - 40% discount on everyday pet products, Rx and preventatives • AskVet (dogs & cats only) - 24/7 Pet Telehealth • ThePetTag (dogs & cats only) - 24/7 Lost Pet Recovery Service	**Single Pet**	**$11.75**
	Family Pet (2+)	**$18.50**

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard & EverGuard Plus plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50