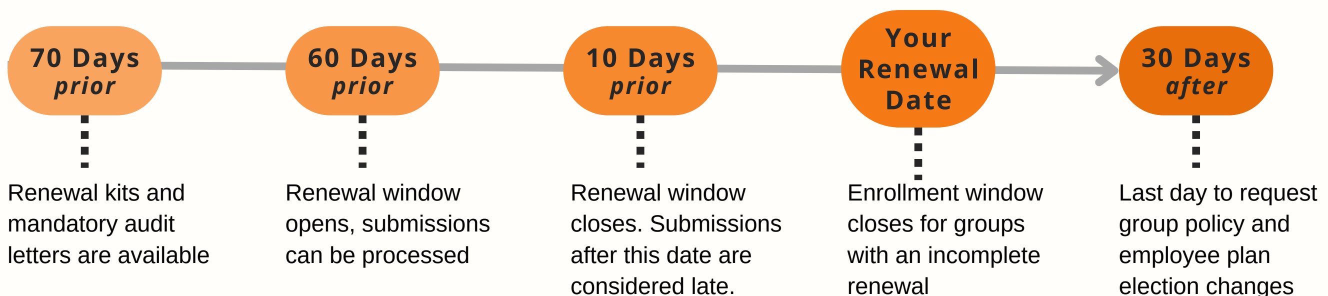
Renewal Requirements

You may be required to submit documentation in order to process your renewal and continue your group policy. This chart indicates what's required for your renewal.

Renewal Type	*Types of Changes*	Action Required
No Changes	*Groups not making changes to their policy or employee plan elections (unless selected for mandatory audit)*	**No documents required**
Employee Plan Changes	*Groups making changes to their employee plan elections only*	**Submit Renewal Attestation Form**
Group Level Changes	*Groups making changes to:* • *Hours worked per week,* • *COBRA Administration participation, and/or* • *Dental/ Vision product offerings that require participation*	***Submit notated tax documents**
	All other group changes not listed above	**Submit Renewal Attestation Form**
Mandatory Audit	*Groups selected for mandatory audit. A notice is sent 90 days prior to your renewal date.*	***Submit notated tax documents**

**Tax documents must be notated with the number of hours worked per week for each employee.*

Renewal Timeline



Late/incomplete submissions received after the 20th of the month prior to the renewal date will be subject to delays and enrollees may experience claim issues.

Find Renewal Forms on our website!

https://healthpass.com/benefits-exchange/forms-and-documents/#renewals

We're here for you, call us 888-313-7277 | renewals@healthpass.com

Renewing Group Attestation Form

I attest that none of the following changes will be made upon renewal for:

Group Name________________________ Group Number________________________

- Changing the number of hours worked per week to be eligible for coverage
- Enrolling in COBRA Administration
- Adding a Vision Package with plan offerings that require participation

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.

Authorized Agent or Employer Signature______________________________________

Print Name______________________________________ Date_____________________

Please complete and submit this form along with any employee plan changes no later than the 20th of the month to ensure that coverage is activated by your renewal date. Late/incomplete submissions will be subject to delays and enrollees may experience claim issues.

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

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

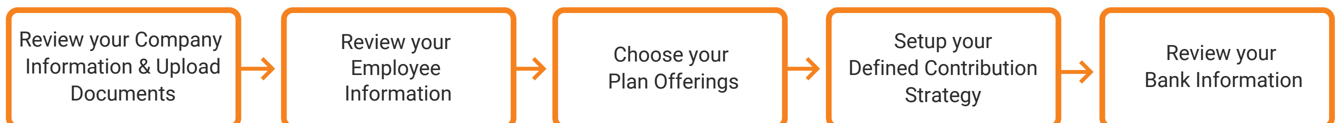
Login to the HealthPass Online Portal (HOP)

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"



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.

We're here for you, call us 888-313-7277 | renewals@healthpass.com

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.

Renewal Application

*Required information

To make changes to your group policy submit this form to your broker or login to your HealthPass Online Portal (HOP) via www.healthpass.com click "Benefits Exchange" then click "login".

Full Name of Company HealthPass Group #

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

SIC Code* ______________________________ SIC lookup here https://siccode.com/sic-code-lookup-directory

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__________

Do you have any commonly owned businesses (Single Employer with common ownership - IRS section 414, subsection (b), (c), (m), or (o))?* ❒Yes ❒No

If offering Anthem PPO/EPO and Blue Access Plans my group will have at least 10 employees enrolled in a HealthPass medical plan and I will contribute a minimum of $750/per month per employee.* ❒I Agree

Pay Frequency* ❒Weekly (52 Contributions) ❒Bi-Weekly (26 Contributions) ❒Semi-Monthly (24 Contributions) ❒Monthly (12 Contributions)

C. YOUR BENEFITS WITH HEALTHPASS

Are you interested in offering FSA & Commuter Benefits to your employees? **(If no, skip to COBRA question.)** ❒Yes ❒No

Initial Enrollment only. If your group is already enrolled in the product, do not reselect it here. **Renew directly with OCA**.

Pay Frequency (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

COBRA/NYSC Administration Services? (included service):* ❒I would like to participate ❒I would like to opt out

COBRA (Federal) or NYSC (State):* ❒Federal (20 or more employees) ❒State (19 or fewer employees)

❒ **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:**

- Number of hours worked per week to be eligible for coverage
- Enrolling in COBRA Administration

D. MEDICAL AND ANCILLARY PLAN OFFERINGS

Participation Requirements:

All Plans Portfolio - for groups domiciled in Manhattan, Brooklyn, Queens, Staten Island, Bronx, Westchester, Rockland, Nassau & Suffolk

Anthem (Connection only), EmblemHealth (all) and Oxford (Metro only) Plans
HealthPass Participation Requirements: 20% of the total eligible employees must enroll with a HealthPass medical plan. 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver.

Additional Participation Requirements:
To include Anthem PPO/EPO and Blue Access Plans:
PPO/EPO and Blue Access Requirements: can be made available to groups with 10 or more enrolling in any medical plan offered through HealthPass with a $750 minimum monthly employer contribution per employee.

If the group does not meet the PPO/EPO and/or Blue Access Requirements at open enrollment: employees who selected PPO/EPO and/or Blue Access plans will need to select alternative plans or they will be mapped into Connection plans within the same selected metal tier. If the member's group is located in a county where Connection plans are not available, enrollment will be pended until an alternative plan is selected by the member.

By offering these plans, the employer attests they are meeting the required monthly contribution per employee stated above.

To include Oxford Freedom and Liberty Plans:
Liberty/Freedom Participation Requirement: 60% of the total eligible employees, after valid waivers, must enroll in a combination of Freedom, Liberty and/or Metro plans.

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

Long Island Easy Par Packages - for groups domiciled in Nassau and Suffolk

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

Mid-Hudson Plans Portfolio - for groups domiciled in Orange, Putnam, Dutchess, Ulster, Sullivan & Delaware

No Participation Requirements apply to Mid-Hudson groups.

Mid-Hudson Plans Portfolio - for groups domiciled in Orange, Putnam, Dutchess, Ulster, Sullivan & Delaware

Choose the medical plans you would like to offer to your employees for the upcoming policy year. You may choose to offer all plans or a select number of plans, though it is recommended to allow employees access to the full portfolio. At every policy renewal you must re-establish the medical plans to offer or all plans will be made available.

No Participation Requirements

Anthem PPO/EPO and Blue Access Plans

PPO/EPO & Blue Access plans - employees can live/work/reside anywhere in the US.†
PPO/EPO & Blue Access Gated (G) plans - employees can live/reside in the 28-county service area.†

❒Platinum EPO 5/25	❒Gold EPO 30/65 G ❒Blue Access Gold EPO 50/60 ❒Blue Access Gold EPO 30/65 G	❒Silver EPO 40/80 ❒Silver EPO 40/80 G ❒Silver EPO HSA 4100 ❒Blue Access Silver EPO 35/75 ❒Blue Access Silver EPO 40/80 G ❒Blue Access Silver EPO HSA 3300	N/A

EmblemHealth Plans

Select Care plans - employees must live/work/reside in NY.

❒Select Care Platinum Premier	❒Select Care Gold Premier	❒Select Care Silver Premier ❒Select Care Silver HSA	❒Select Care Bronze HSA ❒Select Care Bronze Premier

UnitedHealthcare Plans

Choice plans – employees can live anywhere in the continental US.

❒Choice Platinum EPO 15/25 DY-LR ❒Choice Platinum EPO 10/25 DY-LJ ❒Choice Platinum EPO 10/80 DY-MB	❒Choice Gold EPO 40/60 DY-LQ ❒Choice Gold EPO 15/100 DY-MD ❒Choice Gold EPO 30/60 DY-LV ❒Choice Gold EPO 15/30 DY-LK ❒Choice Gold EPO 40/70 DY-LS ❒Choice Gold HSA 1800 DY-LM PR	❒Choice Silver EPO 15/100 DY-MF ❒Choice Silver HSA 3200 DY-LN PR ❒Choice Silver HSA 2750 DY-L7 ❒Choice Silver EPO 30/75 DY-LL	N/A

G = Gated, PR = Premium Rewards

†Anthem PPO/EPO & Blue Access service area consists of five boroughs, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, Dutchess, Ulster, Sullivan, Delaware, Clinton, Essex, Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties (other New York areas and national access BlueCard Network).

Dental Packages

Choose either Package 1 - No Participation Requirements Apply or Package 2 - Participation Requirements Apply
Indicate a change to your dental offering here. If you do not indicate a change, your offering will renew as is.

❒Dental Package 1 - No Participation Requirements Apply

❒Guardian Managed DentalGuard DHMO
❒Guardian Managed DentalGuard DHMO Plus
❒Solstice Dental EPO S700B
❒Solstice Dental EPO S800B
❒Solstice Dental PPO
❒Solstice Dental Value PPO MAC
❒UnitedHealthcare National Exclusive Network

❒Dental Package 2 - Participation Requirements Apply
Participation Requirements – In order for an employee to enroll in a Guardian PPO plan, there needs to be at least one additional enrollee in any Guardian dental plan. In order for an employee to enroll in either the UnitedHealthcare INO or a UnitedHealthcare PPO plan, there needs to be at least one additional enrollee in any UnitedHealthcare dental plan.

❒Guardian Managed DentalGuard DHMO
❒Guardian Managed DentalGuard DHMO Plus
❒Guardian DentalGuard Preferred PPO MAC
❒Guardian DentalGuard Preferred PPO 70 UCR
❒Guardian DentalGuard Preferred PPO 90 UCR
❒Solstice Dental EPO S700B
❒Solstice Dental EPO S800B
❒Solstice Dental PPO
❒Solstice Dental Value PPO MAC
❒UnitedHealthcare National Exclusive Network
❒UnitedHealthcare INO 100/50/50
❒UnitedHealthcare Low PPO MAC
❒UnitedHealthcare High PPO MAC

❒Not Interested

Vision Plans

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

❒Guardian VisionGuard ❒Solstice Vision 5 PPO ❒UnitedHealthcare Vision PPO ❒Not Interested

OCA 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. OCA FSA & Commuter Benefits are processed through HealthPass during the initial enrollment into OCA products (OCA will reach out to you directly to complete the enrollment in these plans). If your group is already enrolled in the product, do not reselect it here. You can only renew it directly with OCA and will receive an email from OCA with renewal instructions. If you haven’t received this email, reach out to OCA at 855-622-0777 or service@oca125.com.

Select any of the plans you wish to offer:
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.

❒**Healthcare Flexible Spending Account (FSA)** Select Yearly Amount Plan: ❍FSA $1,000 Max ❍FSA $2,000 Max ❍FSA $3,300 IRS Max

❒**Dependent Care Account (DCA) FSA** Yearly Maximum Amount: $5,000

❒**Parking Plan** Monthly Maximum Amount: $325

❒**Transit Plan** Monthly Maximum Amount: $325

❒Not Interested

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

Life/AD&D Plans

Indicate a change to your Term Life/AD&D Plan offerings here. If you do not indicate a change, your offering will renew as is.
Employee non-contributory and 100% participation.

❒Employer Paid Life/AD&D 50K ❒Employer Paid Life/AD&D 100K ❒Not Interested

Life Plans

Indicate a change to your Term Life Plan offerings here. If you do not indicate a change, your offering will renew as is.
15% participation requirement

❒Voluntary Life 25K Only ❒Voluntary Life 50K *Only* ❒Dual Option (both) ❒Not Interested

Disability/Life/AD&D Plans

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

❒EverGuard Only ❒EverGuard Plus Only ❒Dual Option (both) ❒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 AccidentGuard Adv ❒Not Interested

Beyond Med Plan

Indicate a change to your Beyond Med Plan offering here. If you do not indicate a change, your offering will renew as is.
This is a discount plan (not insurance).

❒Beyond Med ❒Not Interested

ID Theft Plans

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

❒Allstate Identity Protection	**❒LifeLock**	**❒Not Interested**
❍Allstate Identity Protection	❍LifeLock Benefit Elite Plus	
❍Allstate Identity Protection Pro Plus	❍LifeLock Benefit Elite Premium	

Pet Plan

Indicate a change to your Pet Plan offering here. If you do not indicate a change, your offering will renew as is.
This is a discount plan bundle from Pet Benefit Solutions and includes Pet Assure, Pet Plus, AskVet and The PetTag (not insurance).

❒Total Pet Plan ❒Not Interested

For more valued HealthPass Products & Services 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__________

E. 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 copy of 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 Primary Contact 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.

F. EMPLOYER CERTIFICATION

I agree and attest that:

❒ My business will offer 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 (see page 2)
❒ The group meets all HealthPass carrier enrollment and coverage requirements (see pages 3-5)
❒ This application has been completed with accurate information and has 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.

G. MEDICARE SECONDARY PAYER

The Medicare Secondary Payer (MSP) provisions apply to situations when Medicare is not the primary payer. If your company has employed 20 or more employees in the current or preceding year, Medicare is almost always secondary. In the case where an employer has 19 or fewer employees and is part of a multi-employer group health plan (e.g. HealthPass) then Medicare is by default the primary payer to the group health plan (GHP). Participating employers with HealthPass that certify they have 19 or fewer employees, and have enrolled employees aged 65 or older, must file for the MSP Small Employer Exception Certification.The exception means the employer is not held to the MSP rules governing multi-employer group health plans and Medicare will be the primary payer of Medicare Part A/B claims for any employee that is a working-aged Medicare beneficiary. For the purposes of this calculation both full-time and part-time employees are counted toward the 20 employee threshold. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20 or more employee requirement is met. The 20 or more employee requirement is met if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Note that the 20 weeks do not have to be consecutive. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full and/or part-time employees on its employment payroll each working day of that week.

❒ **Group size per Medicare standards:*_____**

If your answer is 20 or more, no further action needs to be taken. If your answer is 19 or fewer, and you have at least one enrolling employee age 65+, you must complete and sign the MSP Small Employer Exception Certification (https://healthpass.com/wp-content/uploads/2024/11/HealthPass-Small-Employer-Exception-Form.pdf) and submit it with this application.

H. PROGRAM BENEFITS

HealthPass Advocacy: All members with medical coverage through HealthPass have access to additional support with navigating many healthcare related issues, including 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.

I. 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 $3.50, EE/Spouse $4.25, EE+Child(ren) $4.25, Family $5.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $18.25, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian Employer Paid Life/AD&D plans: $3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE $2.00, EE/Spouse $3.00, EE+Child(ren) $3.00, Family $4.50
- Guardian EverGuard & EverGuard Plus plans: $7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $3.50, EE/Spouse $4.50, EE+Child(ren) $4.50, Family $6.50
- ID Theft plans: EE $3.00, Family $5.50
- Pet Benefit Solutions plan: Single Pet $2.00, Family Pet (2+) $4.00

J. 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.

Health Pass BENEFITS EXCHANGE

2025 ENROLLMENT/CHANGE FORM

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

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

A. Enrollments/Additions - Complete A, E, F, T, U and select coverages G -S

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
❒Young Adult Option
❒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, T, U

Requested Effective Date
(1st of the month only)

____/____/____

Waive coverages:
❒Medical
❒Dental

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, T, U and list changes in E, F

Requested Effective Date:

____/____/____

Change Type:
❒Name Change ❒Address Change ❒Other______________________

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

Requested Termination 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 ❒Employer Paid Life/AD&D 50K ❒Employer Paid Life/AD&D 100K	**❒Life** ❒Voluntary Life 25K ❒Voluntary Life 50K
❒Disability/AD&D/LTD ❒EverGuard ❒EverGuard Plus	**❒Accident** ❒Employee ❒Spouse ❒Child(ren)
❒Beyond Med ❒Employee ❒Family	**❒ID Theft** ❒Employee ❒Family
❒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 ❐Domestic Partner ❐Legally Separated ❐Married ❐Single ❐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 ❐Domestic Partner ❐Legally Separated ❐Married ❐Single ❐Widowed			
Relationship*:	❐Spouse	❐Domestic Partner	❐Child	❐Domestic Partner Child	

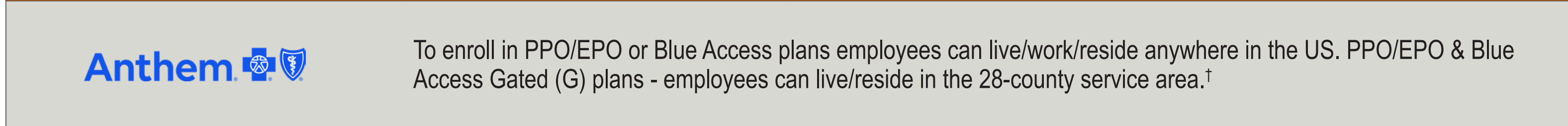
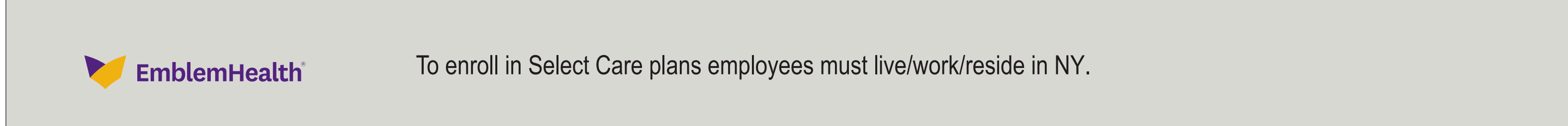
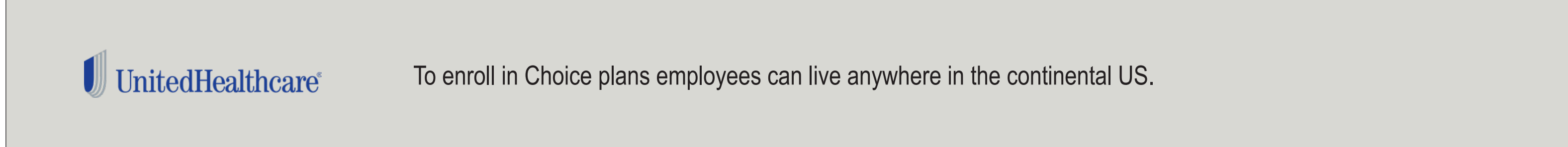
Dependent 2

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 ❐Domestic Partner ❐Legally Separated ❐Married ❐Single ❐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 ❐Domestic Partner ❐Legally Separated ❐Married ❐Single ❐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**
Mid-Hudson Plans Portfolio - confirm with your employer which plans your group offers.			
	To enroll in PPO/EPO or Blue Access plans employees can live/work/reside anywhere in the US. PPO/EPO & Blue Access Gated (G) plans - employees can live/reside in the 28-county service area.†		
❒Platinum EPO 5/25	❒Gold EPO 30/65 G ❒Blue Access Gold EPO 50/60 ❒Blue Access Gold EPO 30/65 G	❒Silver EPO 40/80 ❒Silver EPO 40/80 G ❒Silver EPO HSA 4100 ❒Blue Access Silver EPO 35/75 ❒Blue Access Silver EPO 40/80 G ❒Blue Access Silver EPO HSA 3300	N/A
	To enroll in Select Care plans employees must live/work/reside in NY.		
❒Select Care Platinum Premier	❒Select Care Gold Premier	❒Select Care Silver Premier ❒Select Care Silver HSA	❒Select Care Bronze HSA ❒Select Care Bronze Premier
	To enroll in Choice plans employees can live anywhere in the continental US.		
❒Choice Platinum EPO 15/25 DY-LR ❒Choice Platinum EPO 10/25 DY-LJ ❒Choice Platinum EPO 10/80 DY-MB	❒Choice Gold EPO 40/60 DY-LQ ❒Choice Gold EPO 15/100 DY-MD ❒Choice Gold EPO 30/60 DY-LV ❒Choice Gold EPO 15/30 DY-LK ❒Choice Gold EPO 40/70 DY-LS ❒Choice Gold HSA 1800 DY-LM PR	❒Choice Silver EPO 15/100 DY-MF ❒Choice Silver HSA 3200 DY-LN PR ❒Choice Silver HSA 2750 DY-L7 ❒Choice Silver EPO 30/75 DY-LL	N/A

G = Gated, PR = Premium Rewards

†Anthem PPO/EPO & Blue Access service area consists of five boroughs, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, Dutchess, Ulster, Sullivan, Delaware, Clinton, Essex, Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties (other New York areas and national access BlueCard Network).

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

H. PCP Selection

*****NOTE***** If enrolling in an Anthem G (gated), EmblemHealth 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**	❒DentalGuard Preferred PPO MAC		
	❒Managed DentalGuard DHMO Plus**	❒DentalGuard Preferred PPO 70 UCR	❒ DentalGuard Preferred PPO 90 UCR	
Solstice	❒Dental EPO S700B	❒Dental PPO		
	❒Dental EPO S800B	❒Dental Value PPO MAC		
UnitedHealthcare	❒National Exclusive Network	❒Low PPO MAC		
	❒INO 100/50/50	❒High PPO MAC		

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 Plans

Coverage for (Select one):	❒Employee Only	❒Employee/Spouse	❒Employee/Child(ren)	❒Family
Coverage type (Select one):	❒Guardian VisionGuard	❒Solstice Vision 5 PPO	❒UnitedHealthcare Vision PPO	

L. FSA & Commuter Benefits

Select any of the plans you wish to enroll in and your amount(s) for initial enrollment:

❒**Healthcare Flexible Spending Account (FSA)** **Yearly Amount: $** ________
(Confirm with your employer which plan your group offers FSA $1,000 Max, FSA $2,000 Max, FSA $3,300 IRS Max)

❒**Dependent Care Account (DCA) FSA** **Yearly Amount: $** ________ ($5,000 IRS Max)

❒**Parking Plan** **Monthly Amount: $** ________ ($325 IRS Max)

❒**Transit Plan** **Monthly Amount: $** ________ ($325 IRS Max)

Please process any mid-year OCA enrollments, changes and terminations directly with OCA.

M. Life/AD&D Plans

Coverage type (Select one): ❒Employer Paid Life/AD&D 50K ❒Employer Paid Life/AD&D 100K

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

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

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

N. Life Plans

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

Coverage type (Select one): ❒Voluntary Life 25K ❒Voluntary Life 50K

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

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

O. Disability/Life/AD&D Plans

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*

P. Accident Plan

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*

Q. Beyond Med Plan

Coverage type (Select one): ❒Employee ❒Family

This is a discount plan (not insurance).

R. ID Theft Plans

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 ❒Family

Coverage type (Select one): ❒Benefit Elite Plus ❒Benefit Elite Premium

S. Pet Plan

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).

T. 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 are 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__________________

U. 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__________________

V. Extra Products & Services

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

Health Pass™ BENEFITS EXCHANGE

Benefits Exchange Ancillary Plans & Rates

Monthly Rates for Effective Dates - 4/1/2025, 5/1/2025, 6/1/2025

Dental Package 1 - No Participation Requirements Apply		
Guardian Managed DentalGuard DHMO		Four Tier
● $5 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months ● No deductible, annual calendar maximum, pre-ex & waiting periods ● Fixed copays for basic & major services ● Orthodontia benefit	**Employee**	**$19.85**
	Emp/Spouse	**$37.07**
	Emp/Child(ren)	**$38.22**
	Family	**$55.32**
Guardian Managed DentalGuard DHMO Plus		Four Tier
● $5 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months ● No deductible, annual calendar maximum, pre-ex & waiting periods ● Lower fixed copays for basic & major services than the DentalGuard DHMO ● Orthodontia benefit	**Employee**	**$22.81**
	Emp/Spouse	**$42.86**
	Emp/Child(ren)	**$46.68**
	Family	**$66.74**
Solstice Dental EPO S700B		Four Tier
● $0 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months ● Open access, no specialist referrals, lower fixed copays for basic & major services than the S800B ● No deductible, annual calendar maximum, pre-ex & waiting periods ● Orthodontia & cosmetic benefit ● Implant benefit via implant network provider only	**Employee**	**$19.37**
	Emp/Spouse	**$35.99**
	Emp/Child(ren)	**$40.32**
	Family	**$55.50**
Solstice Dental EPO S800B		Four Tier
● $0 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months ● Open access, no specialist referrals, fixed copays for basic & major services ● No deductible, annual calendar maximum, pre-ex & waiting periods ● Orthodontia & cosmetic benefit ● Implant benefit via implant network provider only	**Employee**	**$15.56**
	Emp/Spouse	**$28.36**
	Emp/Child(ren)	**$31.65**
	Family	**$43.36**
Solstice Dental PPO		Four Tier
● 100%/100%/60% In-Network, no specialist referrals, no waiting periods; 4 Cleanings per 12 months ● $50 In-Network/$50 Out-of-Network calendar deductible, preventive waiver ● 100%/80%/50% Out-of-Network (80th UCR) ● $2,000 annual maximum In-Network/$1,000 Out-of-Network ● Implant benefit	**Employee**	**$58.90**
	Emp/Spouse	**$105.14**
	Emp/Child(ren)	**$125.82**
	Family	**$163.04**
Solstice Dental Value PPO MAC		Four Tier
● 100%/80%/50% In-Network, no specialist referrals, no waiting periods; 2 Cleanings per 12 months ● $50 In-Network/$50 Out-of-Network calendar deductible, 3 max per family, preventive waiver ● 80%/50%/50% Out-of-Network ● $1,000 annual maximum In-Network/$1,000 Out-of-Network	**Employee**	**$34.25**
	Emp/Spouse	**$68.24**
	Emp/Child(ren)	**$75.06**
	Family	**$106.03**
UnitedHealthcare National Exclusive Network		Four Tier
● $0 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months ● No deductible, annual calendar maximum, pre-ex & waiting periods ● Fixed copays for basic & major services ● Implant benefit	**Employee**	**$19.66**
	Emp/Spouse	**$32.61**
	Emp/Child(ren)	**$39.27**
	Family	**$49.52**

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.
All plans listed above include the following billing & administrative fees:

- Dental In-Network plans: EE $3.50, EE/Spouse $4.25, EE+Child(ren) $4.25, Family $5.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $18.25, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian Employer Paid Life/AD&D plans: $3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE $2.00, EE/Spouse $3.00, EE+Child(ren) $3.00, Family $4.50
- Guardian EverGuard & EverGuard Plus plans: $7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $3.50, EE/Spouse $4.50, EE+Child(ren) $4.50, Family $6.50
- ID Theft plans: EE $3.00, Family $5.50
- Pet Benefit Solutions plan: Single Pet $2.00, Family Pet (2+) $4.00

Benefits Exchange Ancillary Plans & Rates

Monthly Rates for Effective Dates - 4/1/2025, 5/1/2025, 6/1/2025

Dental Package 2 - Participation Requirements Apply - In order for an employee to enroll in a Guardian PPO plan, there needs to be at least one additional enrollee in any Guardian dental plan. In order for an employee to enroll in either the UnitedHealthcare INO or a UnitedHealthcare PPO plan, there needs to be at least one additional enrollee in any other UnitedHealthcare dental plan.

Guardian Managed DentalGuard DHMO

- $5 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months
- No deductible, annual calendar maximum, pre-ex & waiting periods
- Fixed copays for basic & major services
- Orthodontia benefit

	Four Tier
Employee	**$19.85**
Emp/Spouse	**$37.07**
Emp/Child(ren)	**$38.22**
Family	**$55.32**

Guardian Managed DentalGuard DHMO Plus

- $5 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months
- No deductible, annual calendar maximum, pre-ex & waiting periods
- Lower fixed copays for basic & major services than the DentalGuard DHMO
- Orthodontia benefit

	Four Tier
Employee	**$22.81**
Emp/Spouse	**$42.86**
Emp/Child(ren)	**$46.68**
Family	**$66.74**

Guardian DentalGuard Preferred PPO MAC

- 100%/80%/50% In-Network, no specialist referrals, no waiting periods; Cleaning every 6 months
- $50 In-Network/$75 Out-of-Network calendar deductible, preventive waiver
- 80%/80%/50% Out-of-Network
- $1,000 annual maximum In-Network/Out-of-Network combined, rollover benefit
- Implant benefit

	Four Tier
Employee	**$43.66**
Emp/Spouse	**$91.68**
Emp/Child(ren)	**$85.33**
Family	**$133.57**

Guardian DentalGuard Preferred PPO 70 UCR

- 100%/90%/60% In-Network, no specialist referrals, no waiting periods; Cleaning every 6 months
- $50 In-Network/$50 Out-of-Network calendar deductible, preventive waiver
- 100%/80%/50% Out-of-Network
- $1,500 annual maximum In-Network/$1,000 Out-of-Network combined, rollover benefit
- Implant benefit

	Four Tier
Employee	**$52.45**
Emp/Spouse	**$110.44**
Emp/Child(ren)	**$102.46**
Family	**$160.90**

Guardian DentalGuard Preferred PPO 90 UCR

- 100%/80%/50% In-Network, no specialist referrals, no waiting periods; Cleaning every 6 months
- $50 In-Network/$50 Out-of-Network calendar deductible, 3 max per family, preventive waiver
- 100%/80%/50% Out-of-Network
- $1,500 annual maximum In-Network/Out-of-Network combined, rollover benefit, preventive max waiver
- Implant & orthodontia benefit; Child orthodontia benefit $1,500 max

	Four Tier
Employee	**$69.07**
Emp/Spouse	**$145.90**
Emp/Child(ren)	**$147.23**
Family	**$226.88**

Solstice Dental EPO S700B

- $0 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months
- Open access, no specialist referrals, lower fixed copays for basic & major services than the S800B
- No deductible, annual calendar maximum, pre-ex & waiting periods
- Orthodontia & cosmetic benefit
- Implant benefit via implant network provider only

	Four Tier
Employee	**$19.37**
Emp/Spouse	**$35.99**
Emp/Child(ren)	**$40.32**
Family	**$55.50**

Solstice Dental EPO S800B

- $0 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months
- Open access, no specialist referrals, fixed copays for basic & major services
- No deductible, annual calendar maximum, pre-ex & waiting periods
- Orthodontia & cosmetic benefit
- Implant benefit via implant network provider only

	Four Tier
Employee	**$15.56**
Emp/Spouse	**$28.36**
Emp/Child(ren)	**$31.65**
Family	**$43.36**

Solstice Dental PPO

- 100%/100%/60% In-Network, no specialist referrals, no waiting periods; 4 Cleanings per 12 months
- $50 In-Network/$50 Out-of-Network calendar deductible, preventive waiver
- 100%/80%/50% Out-of-Network (80th UCR)
- $2,000 annual maximum In-Network/$1,000 Out-of-Network
- Implant benefit

	Four Tier
Employee	**$58.90**
Emp/Spouse	**$105.14**
Emp/Child(ren)	**$125.82**
Family	**$163.04**

Solstice Dental Value PPO MAC

- 100%/80%/50% In-Network, no specialist referrals, no waiting periods; 2 Cleanings per 12 months
- $50 In-Network/$50 Out-of-Network calendar deductible, 3 max per family, preventive waiver
- 80%/50%/50% Out-of-Network
- $1,000 annual maximum In-Network/$1,000 Out-of-Network

	Four Tier
Employee	**$34.25**
Emp/Spouse	**$68.24**
Emp/Child(ren)	**$75.06**
Family	**$106.03**

UnitedHealthcare National Exclusive Network

- $0 primary care office visit copay - 1st visit is for cleaning, checkup & x-rays; Cleaning every 6 months
- No deductible, annual calendar maximum, pre-ex & waiting periods
- Fixed copays for basic & major services
- Implant benefit

	Four Tier
Employee	**$19.66**
Emp/Spouse	**$32.61**
Emp/Child(ren)	**$39.27**
Family	**$49.52**

UnitedHealthcare INO 100/50/50

- 100%/50%/50% In-Network, no specialist referrals, no waiting periods; 2 Cleaning per 12 months
- $50 member/$150 family In-Network calendar deductible
- $1,000 annual maximum In-Network
- Out-of-Network emergency treatment, if necessary
- Implant & orthodontic benefits

	Four Tier
Employee	**$28.49**
Emp/Spouse	**$54.23**
Emp/Child(ren)	**$56.90**
Family	**$86.32**

UnitedHealthcare Low PPO MAC

- 100%/90%/60% In-Network, no specialist referrals, no waiting periods, 2 Cleanings per 12 months
- $50/$50 individual In/Out-of-Network; $75/$75 family In/Out-of-Network calendar deductible, preventive waiver
- 80%/70%/50% Out-of-Network
- $1,000 annual maximum In-Network & Out-of-Network combined, rollover benefit
- Implant & orthodontic benefits

	Four Tier
Employee	**$45.35**
Emp/Spouse	**$90.46**
Emp/Child(ren)	**$92.88**
Family	**$142.37**

UnitedHealthcare High PPO MAC

- 100%/80%/60% In-Network, no specialist referrals, no waiting periods, 2 Cleanings per 12 months
- $50/$50 individual In/Out-of-Network; $100/$100 family In/Out-of-Network calendar deductible, preventive waiver
- 90%/80%/60% Out-of-Network
- $2,000 annual maximum In-Network & Out-of-Network combined, rollover benefit, preventive max waiver
- Implant & orthodontic benefits

	Four Tier
Employee	**$53.23**
Emp/Spouse	**$106.21**
Emp/Child(ren)	**$106.59**
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.
All plans listed above include the following billing & administrative fees:

- Dental In-Network plans: EE $3.50, EE/Spouse $4.25, EE+Child(ren) $4.25, Family $5.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $18.25, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian Employer Paid Life/AD&D plans: $3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE $2.00, EE/Spouse $3.00, EE+Child(ren) $3.00, Family $4.50
- Guardian EverGuard & EverGuard Plus plans: $7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $3.50, EE/Spouse $4.50, EE+Child(ren) $4.50, Family $6.50
- ID Theft plans: EE $3.00, Family $5.50
- Pet Benefit Solutions plan: Single Pet $2.00, Family Pet (2+) $4.00

Benefits Exchange Ancillary Plans & Rates

Monthly Rates for Effective Dates - 4/1/2025, 5/1/2025, 6/1/2025

Vision

Guardian VisionGuard - No minimum participation

- $10 copay for an exam every 12 months
- $25 copay for lenses & contact lenses every 24 months
- $25 copay for frames every 24 months; retail allowance In-Network $130/Out-of-Network $48
- Davis Vision In-Network; Out-of-Network access as well

	Four Tier
Employee	**$6.12**
Emp/Spouse	**$10.00**
Emp/Child(ren)	**$10.16**
Family	**$15.52**

Solstice Vision 5 PPO - No minimum participation

- $10 copay for an exam every 12 months
- $10 copay for lenses & contact lenses every 12 months
- $10 copay for frames every 12 months; retail allowance In-Network $100/Out-of-Network $45
- Spectera Vision Network In-Network; Out-of-Network access as well

	Four Tier
Employee	**$6.53**
Emp/Spouse	**$11.80**
Emp/Child(ren)	**$13.45**
Family	**$18.77**

UnitedHealthcare Vision PPO - No minimum participation

- $10 copay for an exam every 12 months
- $25 copay for lenses & contact lenses every 12 months
- $25 copay for frames every 12 months; retail allowance In-Network $130/Out-of-Network $45
- Spectera Vision Network In-Network; Out-of-Network access as well

	Four Tier
Employee	**$6.69**
Emp/Spouse	**$12.09**
Emp/Child(ren)	**$13.79**
Family	**$19.23**

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 Employee Per Month (PEPM)	**$8.00**

Life/AD&D

Guardian Employer Paid Life/AD&D 50K - Employee non-contributory 100% participation

- $50,000 of Term Life Insurance Coverage
- Enhanced AD&D - 100% of life benefit
- Guaranteed Issue - open enrollment
- Accelerated Life Benefit - terminal condition

Per Employee Per Month (PEPM)	**$14.50**

Guardian Employer Paid Life/AD&D 100K - Employee non-contributory 100% participation

- $100,000 of Term Life Insurance Coverage
- Enhanced AD&D - 100% of life benefit
- Guaranteed Issue - open enrollment
- Accelerated Life Benefit - terminal condition

Per Employee Per Month (PEPM)	**$26.00**

Life

Guardian Voluntary Life 25K - 15% participation

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Employee	$4.13	$4.33	$5.10	$6.33	$8.90	$13.35	$19.53	$26.38	$44.60	$85.40
EE/Spouse	$6.40	$6.72	$7.96	$9.92	$14.04	$21.16	$31.04	$42.00	$71.16	$136.44
EE/Child(ren)	$6.20	$6.40	$7.17	$8.40	$10.97	$15.42	$21.60	$28.45	$46.67	$87.47
Family	$8.97	$9.29	$10.53	$12.49	$16.61	$23.73	$33.61	$44.57	$73.73	$139.01

Guardian Voluntary Life 50K - 15% participation

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Employee	$6.25	$6.65	$8.20	$10.65	$15.80	$24.70	$37.05	$50.75	$87.20	$168.80
EE/Spouse	$8.53	$9.05	$11.06	$14.25	$20.94	$32.51	$48.57	$66.38	$113.76	$219.84
EE/Child(ren)	$8.32	$8.72	$10.27	$12.72	$17.87	$26.77	$39.12	$52.82	$89.27	$170.87
Family	$11.10	$11.62	$13.63	$16.82	$23.51	$35.08	$51.14	$68.95	$116.33	$222.41

Disability/Life/AD&D

Guardian EverGuard - No minimum participation

- $1,000 per month of Disability Income
- $25,000 of Term Life Insurance
- $75,000 of Accidental Death & Dismemberment Insurance
- Guaranteed Issue - open enrollment

Employee Ages	Three Tier
18-39	**$17.50**
40-54	**$30.00**
55+	**$52.50**

Guardian EverGuard Plus - No minimum participation

- $1,500 per month of Disability Income
- $50,000 of Term Life Insurance
- $100,000 of Accidental Death & Dismemberment Insurance
- Guaranteed Issue - open enrollment

Employee Ages	Three Tier
18-39	**$25.50**
40-54	**$43.50**
55+	**$79.50**

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.
All plans listed above include the following billing & administrative fees:

- Dental In-Network plans: EE $3.50, EE/Spouse $4.25, EE+Child(ren) $4.25, Family $5.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $18.25, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian Employer Paid Life/AD&D plans: $3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE $2.00, EE/Spouse $3.00, EE+Child(ren) $3.00,
- Guardian EverGuard & EverGuard Plus plans: $7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $3.50, EE/Spouse $4.50, EE+Child(ren) $4.50, Family $6.50
- ID Theft plans: EE $3.00, Family $5.50
- Pet Benefit Solutions plan: Single Pet $2.00, Family Pet (2+) $4.00

Benefits Exchange Ancillary Plans & Rates

Monthly Rates for Effective Dates - 4/1/2025, 5/1/2025, 6/1/2025

Plan / Benefits	Coverage	Rate
Accident		
Guardian AccidentGuard Adv		Four Tier
● X-rays, emergency room & urgent care facility treatment ● Hospital admission & confinement as well as ICU ● Occupational or physical therapy ● Transportation such as ambulance & air ambulance ● Household expenses towards rent, mortgage and/or food ● Injury-related modifications to your home and/or auto	**Employee**	**$15.83**
	Emp/Spouse	**$24.63**
	Emp/Child(ren)	**$24.81**
	Family	**$34.61**
Health, Wellness & Cosmetic		
Beyond Med (discount plan)		Two Tier
● Membership program offering up to 20% reduced costs on elective & cosmetic services ● Services include fertility, dermatology, med spa, plastic surgery, acupuncture, bariatrics & more ● Exclusive network of board-certified doctors & licensed providers ● No benefit usage limitations for in-network providers, no claims & no waiting periods	**Employee**	**$11.99**
	Family	**$23.99**
ID Theft		
Allstate Identity Protection Pro		Two Tier
● Identity & credit monitoring ● Financial transaction monitoring ● Social Media reputation monitoring ● 24/7 Privacy Advocate remediation ● $1 million identity theft insurance policy	**Employee**	**$10.95**
	Family	**$19.45**
Allstate Identity Protection Pro Plus		Two Tier
● Includes all the benefits of the Allstate Identity Protection Pro plan with added features ● Tri-bureau credit alerts & unlimited credit reports from TransUnion ● In-app Credit Lock ● IP address Monitoring ● 401(k) and HSA stolen fund reimbursement ● Tax fraud refund advances	**Employee**	**$12.95**
	Family	**$23.45**
LifeLock Benefit Elite Plus		Two Tier
● LifeLock Identity Alert System ● Stolen Wallet Protection; Address Change Verification ● Dark Web Monitoring ● Bank & Credit Card Activity Alerts ● Stolen Fund Reimbursement: Up to $1 Million ● One-bureau credit monitoring	**Employee**	**$11.49**
	Family	**$22.48**
LifeLock Benefit Elite Premium		Two Tier
● Benefit Elite Premium plan includes all of the Benefit Elite Plus plan with added features: ● Identity Lock ● Home Title Monitoring ● Checking & Savings Account Application Alerts & Bank Account Takeover Alerts ● Three-bureau credit monitoring ● Monthly Credit Reports, Credit Scores & Score Tracking	**Employee**	**$16.99**
	Family	**$33.48**
Pet Benefit Solutions		
Total Pet Plan (discount plan bundle)		Two Tier
● Pet Assure (any type of pet) - 25% discount from participating vets in US & PR, applies to all in-house medical services, no pre-ex ● PetPlus (dogs & cats only) - 40% discount on everyday pet products, Rx & preventatives ● AskVet (dogs & cats only) - 24/7 Pet Telehealth ● ThePetTag (dogs & cats only) - 24/7 Lost Pet Recovery Service	**Single Pet**	**$13.75**
	Family Pet (2+)	**$22.50**

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.
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