UPRISE PARTNERS LLC
MAY 1, 2024 BENEFIT ELECTION FORM
Please complete and return this form to Human Resources regardless of whether selecting or waiving coverage

Harvard Pilgrim Health Care	Clear Choice POS Silver 3000 MD 201177 (RX 201126)	PPO HSA Silver 3300 MD 201232 (RX 201123)** (Embedded Ded.)	Maine's Choice Plus HMO HSA Silver 3300 MD 201231 (RX 201123)** (Embedded Ded.)	
EFFECTIVE DATE	5/1/2024	5/1/2024	5/1/2024	
NETWORK	POS	PPO	*PREFERRED*	*STANDARD*
DEDUCTIBLE (Single / Family)	$3,000 / $6,000 (IN) $6,000 / $12,000 (OUT)	$3,300 / $6,600 (IN) $6,600 / $13,200 (OUT)	$3,300 / $6,600	$6,300 / $12,600
COINSURANCE	40% (IN) / 50% (OUT)	30% (IN) / 50% (OUT)	30%	50%
TOTAL OUT OF POCKET (Single / Family)	$9,100 / $18,200 (IN) $18,200 / $36,400 (OUT)	$7,500 / $15,000 (IN) $15,000 / $30,000 (OUT)	$7,500 / $15,000 Combined Preferred & Standard	
INPATIENT HOSPITAL SERVICES	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
OUTPATIENT DAY SURGERY	$300 Non-Hospital (IN) or DED & COINS	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
PROFESSIONAL FACILITY	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
PRIMARY CARE VISIT	$40 (IN)	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
SPECIALIST VISIT	$80 (IN)	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
CHIROPRACTIC SERVICES	$40 (IN)	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
ROUTINE PHYSICAL EXAM	$0 (IN)	$0 (IN)	$0	
ANNUAL GYN VISIT	$0 (IN)	$0 (IN)	$0	
ROUTINE EYE EXAM	$40 (IN)	$0 (IN)	$0	DED & COINS
MRI/CAT/PET SCAN	$250 Non-Hospital (IN) or DED & COINS	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
DIAGNOSTIC TESTING	$15 Non-Hospital Lab or DED & COINS	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
PHYSICAL, SPEECH & OCC. THERAPY (60 VISITS/YR.)	$40 Non-Hospital/Office or DED & COINS	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
AMBULANCE	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	PREFERRED DED, THEN 30% COINS	
URGENT CARE	$40 (IN)	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	
EMERGENCY ROOM	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	PREFERRED DED, THEN 30% COINS	
DRUG CARD (30 DAY SUPPLY)	$15/ $25/ $50/ DED, then 30% to $300 Script Max/ DED, then 50% to $600 Script Max	**DEDUCTIBLE, THEN $5/ $25/ $50/ 30% to $300 Script Max/ 30% to $600 Script Max	**DEDUCTIBLE, THEN $5/ $25/ $50/ 30% to $300 Script Max/ 30% to $600 Script Max	
MAIL ORDER RX (90 DAY SUPPLY)	$30/ $50/ $100/ DED, then 30% to $600/ DED. Then 50% to $1,200 Script Max	**DEDUCTIBLE, THEN $10/ $50/ $100/ 30% to $600 Script Max/30% to $1,200 Script Max	**DEDUCTIBLE, THEN $10/ $50/ $100/ 30% to $600 Script Max/30% to $1,200 Script Max	
MAXIMUM BENEFIT	UNLIMITED			

Value 5-Tier Formulary: Pref. Generic/ Non-Pref. Generic/ Pref. Brand/ Non-Pref. Brand & Pref. Specialty/ Non-Pref. Specialty)
**HSA plan includes Preventive Drug Benefit. Certain preventive drugs are exempt from the Deductible. However, preventive drugs are still subject to any copayment or coinsurance.
****HSA FUNDING:** If enrolled in the PPO Silver HSA 3300 or Maine's Choice Plus HMO HSA Silver 3300 plan, employees can elect an amount per pay period to fund a Health Savings Account. If interested, see page 2 to indicate the amount.

MEDICAL EMPLOYEE DEDUCTIONS PER PAY PERIOD (BI-MONTHLY)			
EMPLOYEE	$0.00	$0.00	$0.00
EMPLOYEE & SPOUSE	$243.00	$241.36	$211.20
EMPLOYEE & CHILDREN	$206.55	$205.15	$179.52
FAMILY	$510.30	$506.84	$443.51

NORTHEAST DELTA DENTAL & VISION EMPLOYEE DEDUCTIONS PER PAY PERIOD (BI-MONTHLY)		
	DENTAL	***VISION***
EMPLOYEE	$14.03	$2.58
EMPLOYEE & 1 DEPENDENT	$25.67	$4.43
EMPLOYEE & 2 OR MORE	$44.90	$7.92

This is a summary only. Please reference HPHC Summary of Benefits for furthers details and any limitations on benefits. Plan documents govern.

Employee Name _____

MAY 1, 2024 MEDICAL, DENTAL & VISION PLAN OPTIONS

Check the box next to the plan you would like to select:	Employee Only	Employee & Spouse	Employee & Children	Family
Clear Choice POS Silver 3000 MD 201177 (RX 201126)				
PPO HSA Silver 3300 MD 201232 (RX 201123)**				
Maine's Choice Plus HMO HSA Silver 3300 MD 201231 (RX 201123)**				

** If selecting PPO HSA Silver 3300 or Maine's Choice Plus HMO HSA Silver 3300, please indicate amount here if you would like an amount deducted per pay period from your check to fund your HSA account: $_____

	Employee Only	Employee & 1 Dependent	Employee & 2 or More Dependents
Northeast Delta Dental			
Northeast Delta Vision			

Election Agreement. I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or my spouse's death; a change in the number of my federal tax dependents due to birth, adoption, placement for adoption, or death; a change in employment status for me, my spouse or federal tax dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes my federal tax dependent to satisfy or cease to satisfy status as a dependent; a change in my, my spouse's or my dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events is defined in the **Summary Plan Description** and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a non-flexible spending account benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

_____

Signature Date

—OR—

Waiver of election. I have reviewed the Group Medical, Dental and Vision plan offers and at this time I am waiving my right to election. If you refuse coverage for yourself then you automatically refuse coverage for your dependents. If you refuse coverage now, and later request to add that benefit, entry restrictions may apply.

MEDICAL ☐ DENTAL ☐ VISION ☐

_____

Signature Date

All Employees Complete:

_____

Name

_____

Address

_____

City **State** **Zip**