RoNetco Supermarkets
2025 Associate Benefit Enrollment
Associate Plan Menu and Contributions

☐ New Hire ☐ Life Event ☐ Open Enrollment

Associate Name: _____ #300 Number: _____

Social Security Number: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

ACO Network (for associates living in CT, NJ, and NY only)

Aetna Whole Health

Basic Managed Choice Plan (Bronze)

Associate Contributions (Weekly)

☐ Associate Only: **See your Benefits Administrator**

☐ Associate + Family: **See your Benefits Administrator**

Managed Choice Plan (Silver Plus)

Associate Contributions (Weekly)

☐ Associate Only: **See your Benefits Administrator**

☐ Associate + Family: **See your Benefits Administrator**

HCRA Plan (Aetna Healthfund)

Associate Contributions (Weekly)

☐ Associate Only: **See your Benefits Administrator**

☐ Associate + Family: **See your Benefits Administrator**

Broad Network

Aetna Managed Choice POS Network

Basic Managed Choice Plan (Bronze)

Associate Contributions (Weekly)

☐ Associate Only: **See your Benefits Administrator**

☐ Associate + Family: **See your Benefits Administrator**

Managed Choice Plan (Silver Plus)

Associate Contributions (Weekly)

☐ Associate Only: **See your Benefits Administrator**

☐ Associate + Family: **See your Benefits Administrator**

HCRA Plan (Aetna Healthfund)

Associate Contributions (Weekly)

☐ Associate Only: **See your Benefits Administrator**

☐ Associate + Family: **See your Benefits Administrator**

☐ **Medical Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

NOTE: You must complete and return the **WAIVER OF HEALTH PLAN COVERAGE AND VERIFICATION OF OTHER HEALTH COVERAGE** form.

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Associate Name:

Dental: Aetna

Aetna Dental Plan

Associate Contributions (Weekly)

☐ Associate Only: **$0.00**

☐ Associate + Family: **$0.00**

☐ **Dental Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

Vision: EyeMed

EyeMed Vision Plan: Option 1

Associate Contributions (Weekly)

☐ Associate Only: **$0.00**

☐ Associate + Family: **$2.00**

EyeMed Vision Plan: Option 2

Associate Contributions (Weekly)

☐ Associate Only: **$1.00**

☐ Associate + Family: **$4.00**

☐ **Vision Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

For administration use only.

Associate Hire Date:

Effective Date:

Effective Date Notes:

Billing Store:

Additional Notes:

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Associate Name:

Dependent Enrollment

Please attach applicable Marriage Certificate/Birth Certificate for anyone you are adding.

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:
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Name: Date of Birth: Relationship: SSN:
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Name: Date of Birth: Relationship: SSN:
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Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

WAIVER OF HEALTH PLAN COVERAGE AND VERIFICATION OF OTHER HEALTH COVERAGE

Employee Name: _____ Social Security Number: _____

I understand that I am eligible for health benefit coverage provided under the RONETCO SUPERMARKETS, INC. health and welfare plan (the "Plan"). The benefits under the Plan and the contribution I would have to make to be covered for these benefits have been explained to me in detail.

I certify that I have health benefits from another source:

Name of organization providing coverage: _____
Address: _____
Insurance Carrier: _____
Group Number: _____

If eligible for dependent coverage, I further certify that my dependents have health benefits from another source.

Name of organization providing coverage: _____
Address: _____
Insurance Carrier: _____
Group Number: _____

I, therefore, decline health benefit coverage under the Plan and waive all claims to Plan benefits.

I understand that if I request coverage for myself and/or my eligible dependent(s) at a later date, I may be required to wait until the next open enrollment period, if eligible at such time. However, I and my dependent(s) will not be required to wait until the next open enrollment period if:

(1) I and my dependent children, as applicable, are otherwise eligible to enroll in health coverage under the Plan,

(2) The other coverage described above is terminated as a result of (a) loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), (b) termination of employer contributions toward the coverage or (c) exhaustion of COBRA coverage (in the event the other coverage was provided under a COBRA continuation provision), and

(3) I request enrollment in this Plan not later than 30 days after the date that coverage is terminated.

_____
Signature of Associate

_____ _____
Print Name of Associate Date Signed

IMPORTANT: Although you are refusing health plan coverage, you may be eligible for other benefits fully paid for by RONETCO SUPERMARKETS, INC.. Please speak to the Benefits Administrator or Human Resources if you have any questions.