COUNTY OF SUMMIT
EMPLOYEE ELIGIBILITY AND ADULT DEPENDENT COVERAGE

To be eligible for benefit coverage, you must be a full-time employee working at least 30 hours per week. Benefits are effective on the employee's date of hire.

Eligible dependents include:

- The employee's spouse
- The employee or spouse's:
    - Natural children
    - Stepchildren
    - Children placed for adoption or legally adopted children
    - Children for whom either the employee or spouse is the legal guardian or custodian
    - Any children who, by court order, must be provided health care coverage by the employee or employee's spouse.

Eligibility verification is only required once upon enrolling in the Summit County Benefit Plan for employees and dependents. You have 30 days from your effective date to submit your Employee Benefit Enrollment and Change Application with your one-time verification forms for you and your dependents. (See Required Documents section.)

QUALIFYING EVENTS

Marriage

- Addition of Spouse. The Division of Employee Benefits Department must be notified within 30 days of an employee marriage in order for the spouse to be enrolled on the County plan. Remember to update beneficiaries at this time if you choose.

Divorce/Dissolution/Legal Separation

- An application/change form must be submitted to the Division of Employee Benefits Department when there is a change in marital status. Employees must notify the Division of Employee Benefits Department within 30 days in the case of divorce, dissolution or legal separation so that COBRA can be offered within 60 days. Remember to update beneficiaries at this time if you choose.

Birth/Adoption of a Child

- The addition of a dependent. Employees must notify the Division of Employee Benefits Department within 30 days of the birth or adoption of a child in order for coverage to begin on the event date.

Birthday/Dependent Age Limit

- Check your plan to see if your dependent children are eligible beyond age 26. If your dependent no longer meets the eligibility criteria, employees must notify the Division of Employee Benefits Department immediately so that COBRA can be offered within 60 days of their 26th birthdate.

All Qualifying Event changes must be reported to the Employee Benefits department within 30 days of the date of event. Changes must be submitted on an Employee Benefits Enrollment and Change Application and must be accompanied by the appropriate Required Document listed below.

<u>REQUIRED DOCUMENTS</u> (Required for new hires and qualifying events)

Employee/Spouse

- Copy of Marriage License (Legal Copy)
- Copy of Divorce Decree (if applicable)/Separation Agreement

Child

- Legible copy of birth certificate (not proof of birth letter) listing employees name
- Copy of adoption or guardianship papers listing employee and child (if applicable)

Step-Child

- Legible copy of birth certificate showing one or both parent's name.

  Please note: In addition to the birth certificate you must be able to prove the employee/step-child relationship (a valid birth certificate along with a valid marriage certificate listing both employee and spouse would prove the employee is tied to the step-child)

- Copy of a valid court order showing who is responsible for providing healthcare coverage with one or both parent's name.

  Please note: In addition to the court order you must be able to prove the employee/step-child relationship (a valid court order along with a valid marriage certificate listing both employee and spouse would prove the employee is tied to the step-child) Federal law allows eligible dependent married or unmarried children to be covered until they reach age 26.

<u>CHANGE OF ADDRESS</u>

- Notify the Division of Employee Benefits Department immediately anytime there is a change of address.

<u>IMPORTANT ENROLLMENT REQUIREMENTS</u>

YOU MUST REPORT ALL CHANGES IN FAMILY STATUS TO THE DIVISION OF EMPLOYEE BENEFITS WTITHIN 30 DAYS OF THE OCCURRENCE. FAILURE TO REPORT CHANGES IN A TIMELY MANNER MAY RESULT IN DELAY OR DENIAL OF COVERAGE OR THE LOSS OF THE OPTION TO EXERCISE COBRA CONTINUATION. IF ELIGIBLE EMPLOYEES, SPOUSES AND DEPENDENTS ARE NOT ENROLLED ON THE BENEFIT PLAN WITHIN 30 DAYS OF THEIR ELIGIBILITY DATE, ENROLLMENT WILL BE DEFERRED TO THE NEXT OPEN ENROLLMENT PERIOD.

SPECIAL ENROLLMENT RIGHTS

You or your Eligible Dependent who has declined the coverage offered by County of Summit may enroll for coverage under this plan during any special enrollment period if you lose coverage or add a dependent for the following reasons, as well as any other event that may be added by federal regulations:

- In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this plan was previously offered.
- If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:
  - Loss of eligibility for coverage as a result of divorce or legal separation
  - Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan)
  - Death of an Eligible Employee
  - Termination of employment
  - Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
  - Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
  - An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
  - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
  - A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)
  - Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
  - The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan
- If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.
- Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "j" (termination of Medicaid or CHIP coverage) and "k" (eligibility for premium assistance) above, notice of intent to enroll must be provided to Medical Mutual by the Group no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "j" and "k" above, notice of intent to enroll must be provided to Medical Mutual by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Eligible Dependents provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact Kym Komaschka, Division of Employee Benefits (330) 643-2621.

2024 Benefit Premiums – County of Summit

The charts below summarize County and Employee benefit premiums for coverage in 2024.

Medical & Prescription Coverage

Medical Mutual PPO Advantage

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$39.18	$352.68
Family	$105.53	$949.79

Medical Mutual MedFlex Plan

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$15.27	$290.12
Family	$41.12	$781.34

Medical Mutual Maximum Value Plan (HSA)

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$15.02	$235.31
Family	$40.45	$633.72

Dental Coverage

MetLife Dental PPO & MAC Plans

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$12.90	n/a
Family	$38.22	n/a

Vision Coverage

Davis Vision

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$1.98	n/a
Family	$5.46	n/a

Cash Waiver Incentive Program – County employees have a cash option that may be exercised if they decline medical and prescription coverage and provide proof that they are covered under another medical plan outside the County's program. County employees that are married or a dependent to each other and elect County coverage under one employee are not eligible for the waiver. Those opting out will receive $50 per month. You will still be eligible for the other employee benefit programs. Employees are subject to the applicable terms of their collective bargaining agreement.

2024 Health Plan Comparison

MEDICAL | Rx
PLAN COMPARISON

	MEDFLEX PLAN*	ADVANTAGE PLAN*		MAXIMUM VALUE PLAN (HSA)	
	In-Network ONLY	In-Network	Non-Network	In-Network	Non-Network
Deductible					
Single	$500	$1,000	$2,000	$3,200	$6,400
Family	$1,000	$2,000	$4,000	$6,400	$12,800
Coinsurance (after deductible)	10%/90%	20%/80%	40%/60%	100%	60%
Single	$2,000	$3,000	$6,000	$0	$11,000
Family	$4,000	$6,000	$12,000	$0	$22,000
Maximum Out of Pocket (Includes deductible, coinsurance and all copays)					
Single	$7,350	$7,350	$22,050	$3,200	$17,400
Family	$14,700	$14,700	$44,100	$6,400	$34,800
Office Visit - PCP/ Specialist	$20/$40	$20/$40	40% after deductible	0% after deductible	40% after deductible
Preventive Office Visit	0%	0%	40% after deductible	0% after deductible	40% after deductible
Emergency Room (waived if admitted)	$150	$150	$150	0% after deductible (true emergency)	0% after deductible (true emergency)
Urgent Care - PCP/ Specialist	$40	$40	40% after deductible	0% after deductible	40% after deductible
Diagnostic Services (Xray and diagnostic medical tests)	20% after deductible	20% after deductible	40% after deductible	0% after deductible	40% after deductible
Diagnostic Lab (Free standing facilities)	$20	$20	40% after deductible	0% after deductible	40% after deductible
Diagnostic Lab (Institutional)	20% after deductible	20% after deductible	40% after deductible	0% after deductible	40% after deductible
				HSA Included	
Prescription Drugs					
Retail Pharmacy	$10/$25/$50 (Brand Copay + difference of cost if generic available)			0% after deductible	
Mail Order/ Smart 90	$20/$50/$100 (Brand Copay + difference of cost if generic available)			0% after deductible	

SaveOnSP
Reducing plan costs by maximizing manufacturer's assistance for specialty drugs.

The SaveonSP program saves Medical Mutual members money by maximizing prescription drug copay assistance from pharmaceutical manufacturers. With SaveonSP, plan savings on specialty drugs average nearly 13 percent while members' out-of-pocket responsibility is reduced to $0. Specialty drugs are filled exclusively by Accredo or Gentry Health Solutions.

This is a Prescription Advocacy Program that assists employees and their dependents with their out-of-pocket costs on high cost medications. Employees with a high cost prescription medication will be contacted via phone by an ImpaxRX representative to determine if they are eligible to participate in the program.

ImpaxRX

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Network: PDP Plus

	Plan option 1 MAC plan		Plan option 2 PPO Plan	
	In-Network[1] % of Negotiated Fee[2]	**Out-of-Network[1]** % of Maximum Allowable Charge	**In-Network[1]** % of Negotiated Fee[2]	**Out-of-Network[1]** 90% of R&C Fee**
Coverage Type				
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	100%	100%	80%	80%
Type C: Major Restorative (bridges, dentures)	60%	60%	50%	50%
Type D: Orthodontia	50%	50%	50%	50%
Deductible†				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit				
Per Person	$1,750	$1,750	$1,750	$1,750
Orthodontia Lifetime Maximum				
Per Person	$1,500	$1,500	$1,500	$1,500

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2]Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
† Applies only to Type B & C Services.

List of Primary Covered Services & Limitations*

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category,but is not a complete description of the Plan.

Plan Type	Plan Option 1: MAC PLAN How Many/How Often	Plan Option PPO PLAN How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per calendar year	Two per calendar year
Oral Examinations	Two exams per calendar year	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar	One fluoride treatment per calendar year

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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

X-rays	• Full mouth X-rays; one per 36 months • Bitewings X-rays; two sets per calendar year for children & adults	• Full mouth X-rays; one per 36 months • Bitewing X-rays; two sets per calendar year for children & adults
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday	Space maintainers for dependent children up to his/her 14th birthday
Sealants	One application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday	One application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday
Type B — Basic Restorative		
Fillings		
Simple Extractions		
Crown, Denture and Bridge Repairs/ Recementations	1 in 12 months	1 in 12 months
Oral Surgery		
Endodontics	Root canal treatment limited to once per tooth per lifetime	Root canal treatment limited to once per tooth per lifetime
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year
Type C — Major Restorative		
Implants	Replacement once every 84 months	Replacement once every 84 months
Implant services	1 per tooth position in 84 months	1 per tooth position in 84 months
Implant Repairs	1 per tooth in 24 Months	1 per tooth in 24 Months
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed

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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Crowns, Inlays and Onlays	Replacement once every 60 months	Replacement once every 60 months
Type D — Orthodontia		
	• Your children, up to age 19, are covered while Dental insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary. • Orthodontic benefits end at cancellation of coverage	• Your children, up to age 19, are covered while Dental insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary. • Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;

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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Questions & Answers

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at or call to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit or request one by calling

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Q. Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.

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DavisVision™

davisvision.com | 1 (877) 923-2847, 2968

County of Summit your vision plan

Client code: 2968

Frequency

Exam: Every Calendar year
Lenses & lens upgrades: Every Calendar year
Frame: Every Calendar year
Contacts, evaluation & fitting: Every Calendar year

Sign up during open enrollment

For more details about the plan, visit davisvision.com/member and enter your Client Code or call 1 (877) 923-2847 and enter your Client Code when prompted.

Exams & Services

Eye Exam copay:
$15

Contacts evaluation, fitting & follow-up:

Conventional lens	Specialty lens
Covered in full	**$60 allowance plus 15% savings[2]**

Lenses

Lens copay:
$15

Frame

Allowance:

Other locations	Visionworks[1]
$100	**$150**

+Additional 20% **off** any overage.[2]

or

The Exclusive Collection copay:

Fashion	Designer	Premier
Covered in full	**$15**	**$40**

Contacts[3]
in lieu of glasses

Allowance:

$100

+Additional 15% **off** any overage.[2]

or

The Exclusive Collection of Contact Lenses:[4]

Covered in full

Find a network provider...

Enter your client code in the "Member Sign In" section of our website at davisvision.com/member to locate a provider near you including Visionworks.

Using your client code

Log in using your client code (listed above) at davisvision.com/member to find a list of in-network providers near you and access your benefit information.

The Exclusive Collection

The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S. Log in to browse frames, and find a Collection near you.

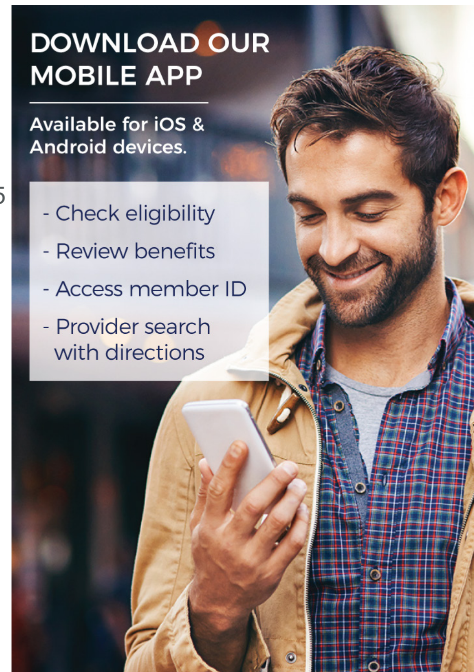
Free breakage warranty

Your glasses are covered with our FREE one-year breakage warranty. Some limitations apply.

Options & upgrades

Lens options

Item	Cost
Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX)	$0
Polycarbonate Lenses (Children / Adults)	$0 or $35
High-Index Lenses 1.67	$60
High-Index Lenses 1.74	$120
Polarized Lenses	$75
Progressive Lenses (Standard / Premium / Ultra/ Ultimate)	$65 / $105 / $140 / $175
Anti-Reflective (AR) Coating (Standard / Premium / Ultra/ Ultimate)	$40 / $55 / $69 / $85
Ultraviolet Coating	$15
Tinting of Plastic Lenses (Solid / Gradient)	$15
Plastic Photochromic Lenses (Transitions® Signature™)	$70
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Scratch-Protection Plan (Single-Vision | Multifocal)	$20 | $40
Digital Single Vision Lenses	$30
Trivex Lenses	$50
Blue Light Filtering	$15



Additional savings

Item	Cost
Retinal imaging (Member charge)	$39
Additional pairs of eyeglasses	30% discount[2]

Out-of-network benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

Out-of-network reimbursement schedule (up to)	
Eye Examination: $15	Trifocal Lenses: $30
Frame: $30	Lenticular Lenses: $40
Single-Vision Lenses: $10	Elective Contact Lenses: $40
Bifocal / Progressive Lenses: $20	Visually Required Contacts: $75

1. Excludes Maui Jim® eyewear. 2. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. 3. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. 4. The Davis Vision Exclusive Collection of Contact Lenses is available at participating providers. Evaluation, fitting and follow-up care for Collection contacts are covered in full. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

Guardian The Guardian Life Insurance Company of America

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: COUNTY OF SUMMIT	Group Plan Number: 00576937	Benefits Effective:_______________

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

Class: VOLUNTARY LIFE-VOLUNTARY AD&D Division:____________________ Subtotal Code:________________________ (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address	City	State	Zip

Gender: ❑ M ❑ F Date of Birth (mm-dd-yy):____ - ____ - ____ Phone: ( ) -

Email Address: Are you married or do you have a spouse? ❑ Yes ❑ No Date of marriage/union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

Voluntary Term Life Coverage:

You must be enrolled to cover your dependents. *Benefit reductions apply. Please see plan administrator.*

Employee

Policy Amount *Check one box only*

❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ $150,000	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ $200,000	❑ $210,000	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000*

*Guarantee Issue Amount.

❑ I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000
❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000*	❑ $55,000	❑ $60,000
❑ $65,000	❑ $70,000	❑ $75,000	❑ $80,000	❑ $85,000	❑ $90,000
❑ $95,000	❑ $100,000	❑ $105,000	❑ $110,000	❑ $115,000	❑ $120,000
❑ $125,000	❑ $130,000	❑ $135,000	❑ $140,000	❑ $145,000	❑ $150,000

**Guarantee Issue Amount*

**The amount may not be more than 50% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ $5,000*

**Guarantee Issue Amount*

**The amount may not be more than 50% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Have you used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco) and/or have you smoked cigarettes in the past 12 months?

Employee Yes ❑ No ❑ Spouse Yes ❑ No ❑

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%)
Primary Beneficiaries:

Name:_______________ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %________

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_______________

Phone: ( ) - Relationship to Employee:_______________

Name:_______________ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %________

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_______________

Phone: ( ) - Relationship to Employee:_______________

Contingent Beneficiary:_______________ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ Address/City/State/Zip:_______________

Phone: ( ) - Relationship to Employee:_______________

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Accidental Death and Dismemberment Coverage:

You must be enrolled to cover your dependents. Check only one box.

Employee Only

Policy Amount

❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ $150,000	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ $200,000	❑ $210,000	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000*

❑ I do not want this coverage

Add Entire Family (includes Employee, Spouse and Child(ren))

❑ Spouse 50% of employee's amount & Child(ren) 10% of employee's amount

❑ I do not want this coverage

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person’s insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X ______________________________ DATE ____________________

Enrollment Kit 00576937, 0001, EN

HEALTH PLANS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The County of Summit sponsors a combination of health plans for the benefit of its participants, including medical, dental, and vision plans as well as health care spending accounts (collectively referred to as the "Plan"). To better serve the participants, the County and its health plans need to coordinate the operations of these plans. This Notice applies to all of the health plans sponsored by the County to enable them to share health information as necessary for treatment, payment or health care operations.

The Plan is required by law to maintain the privacy of your health information, to provide you with notice of its legal duties and privacy practices with respect to your health information, and to notify you following a breach of your protected health information ("PHI"). The Plan is required to follow the privacy practices described in the most current Notice. The effective date is listed at the end of the Notice.

This Notice describes how the Plan has extended certain protections to your PHI and how, when, and why we may use and disclosure your PHI. With certain exceptions, the Plan will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. The Plan will share PHI as necessary to provide reimbursement for your services as permitted by law.

We reserve the right to change our privacy practices and the terms of this Notice at any time. If we make a material revision to the Notice, we will provide you with a revised copy of the Notice as required by law. We will also have our Notice available upon request.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The Plan is committed to maintaining the confidentiality of your PHI. Your PHI may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses and the others outlined below, we will not disclose your PHI without a signed authorization from you, unless the law permits or requires us to use or disclose this information without your authorization. You have the right to revoke any authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment. The Plan may release your PHI to another health care facility or professional who is not affiliated with this organization but who is or will be providing treatment to you. For instance, if, after you leave the hospital, you are going to receive home health care, the Plan may release your PHI to that home health care agency so that a plan of care can be prepared for you.

Payment. The Plan will make uses and disclosures of your PHI as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, the Plan may forward information regarding your medical procedures and treatment in order to arrange payment for the services provided to you, or the Plan may use your information to prepare a bill to send to you or the person responsible for your payment.

Health Care Operations. The Plan may release your PHI as necessary for health care operations purposes. This may include, but is not limited to, use or disclosure for clinical improvement, professional peer review, business management, accreditation, and licensing, activities. The Plan is prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Stricter Law. Certain provisions of Ohio law may be more stringent than the federal laws and regulations protecting the privacy of your medical information. Specifically, Ohio law requires that we obtain consent from you before disclosing the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition. The Plan will, as required by law, comply with the more stringent provisions of Ohio law.

Business Associates. It may be necessary for us to provide your PHI to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation and legal services. For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your PHI. These business associates are required to properly safeguard the privacy of your PHI.

OTHER USES AND DISCLOSURES OF PHI

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting organizations, health oversight audits or inspections, worker's compensation purposes, and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited PHI with friends and family without your approval.

If you are a member of the armed forces, we may also make disclosures to your personal representative appointed by you or designated by law, to appropriate military authorities, and to inform you of other health related benefits or services that may be of interest to you.

We will not use or disclose your psychotherapy notes except to carry out treatment, payment, or health care operations, use by the creator of the notes for treatment, use or disclosure for training purposes,

or use in a legal action or other proceeding brought by you.

We will not use or disclose your PHI for marketing purposes, including informing you about non-health related products and services, without your authorization except if the communication is a face-to-face communication or a promotional gift. You will be notified if payment is to be made for use or disclosure of your information. We will not sell your PHI without your authorization. You will be notified if payment is to be made for the sale of your information.

We will not disclose your PHI except as described in this Notice and as otherwise required by law. However, if you wish that we otherwise disclose your PHI, you must give us written authorization. To receive an authorization form, please contact the Privacy Officer.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

1. Restrictions on Use and Disclosure of Individual Protected Health Information. You have the right to request that we restrict how we use and disclosure your PHI. These restrictions must be made in writing to the Privacy Officer and signed by you or your representative. You must advise us: 1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.

2. Access and/or Copying Your Protected Health Information. You have the right to request to inspect and/ or copy your PHI. Your request must be in writing on an access form that you can obtain from the Privacy Officer. You or your legal representative must sign the form and return it to the Privacy Officer. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies or access. Depending on the circumstances, you may request a review of the decision to deny access. If we deny your request, you will be given written notice that will explain the basis of the denial and your right to appeal. The Plan must make PHI available in electronic format upon request and where available. You may request that copies of your PHI be sent to a third party.

3. Amendments to Individual Protected Health Information. You have the right to request that your PHI be amended or corrected. In certain cases, we may deny your request for amendment. If so, you will be given written notice explaining the basis and your right to appeal. You may also submit a statement of disagreement to the denial. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of your record if we believe that such notification is necessary. You may obtain a Request for amendment form from the Privacy Officer.

4. Accounting for Disclosures of Individual Protected Health Information. You have the right to receive an accounting of certain disclosures of your PHI made by us within the last 6 years. Requests must be made in writing and signed by you or your representative. Request for accounting forms are available from the Privacy Officer. The first accounting in any 12-month period is free, but the Plan may charge you for additional accountings within the same 12-month period. The Plan will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

5. Confidential Communications. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your PHI from us by alternative means or at

alternative locations. You may request such confidential communication by sending your written request to the Privacy Officer.

6. ***Right to Paper Copy.*** You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to Privacy Officer.

7. ***Complaints***. If you believe that we may have violated your privacy rights, or you disagree with a decision about your PHI, you may file a complaint with the Privacy Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. Such request must be made within 180 days of when the act or omission complained of occurred . **There will be no retaliation for filing a complaint.**

Contact Information. If you have any questions about this notice, please contact

County of Summit Privacy Officer
175 S. Main Street
8th floor, Department of Law and Risk Management
Akron, Ohio, 44308
Phone Number: 330.643.8052

You may view this Notice or any new notices on the website: ***www.co.summit.oh.us***

Effective Date: 01.2019
Reviewed: 10/19/2022

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact ____
.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name			4. Employer Identification Number (EIN)
5. Employer address			6. Employer phone number
7. City	8. State		9. ZIP code
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)	12. Email address		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?____________________ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_______________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?____________
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $______________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)