2017
Benefits Enrollment Guide

Your wellness is our focus.

Welcome to your 2017 Employee Benefits Guide

We recognize the important role employee benefits play as a critical component of your overall compensation. As such, Evans Animal Hospital continues to make every effort to target the best quality benefit plans for our employees and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well being and financial security of you and your covered dependents. Helping you understand the benefits Evans Animal Hospital offers is important to us, and that is why we have created this Employee Benefits Guide.

Benefits Guide Overview

Evans Animal Hospital is proud to be able to offer high quality benefits. This Benefit Guide, along with your Benefit Summaries, provides an explanation of the benefits available to you and your family.

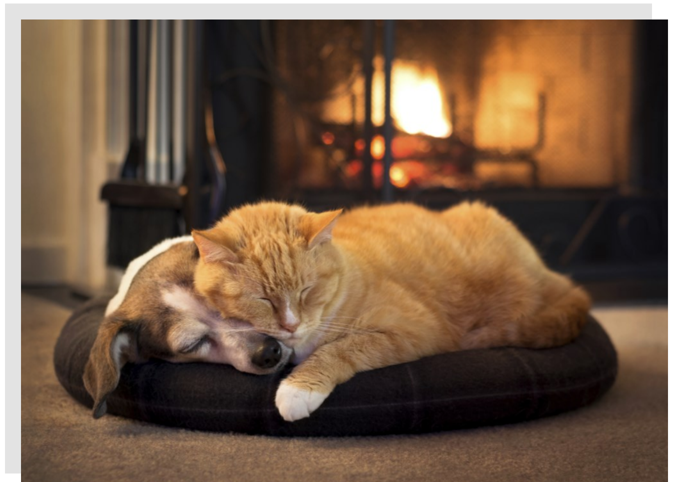
This is your enrollment opportunity. At this time, you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until April 1, 2018 unless you or your dependents experience a qualified life event (See Box below).

Changing Benefits During the Year

The IRS states that eligible employees may only make elections to the plan during their initial eligibility period or once a year at open enrollment. The following circumstances are the only reasons you may change your benefit elections during the year:

Marriage	Death of a Spouse
Divorce	Death of a Dependent
Birth or Adoption	Loss of a Dependent
Change in Employment Status, Addition of a New Benefits Package, and Open Enrollment for a Spouse.	

These special circumstances, often referred to as life event changes, allow you to make plan changes at any time during the year when they occur. You must inform your Employee Benefits Department within 30 days of the event in order to make a qualified change. All other changes will be deferred to open enrollment.



YOUR BENEFITS

Benefit Summary

Georgia - Choice Plus
Balanced - 20/1000/80% Plan G2Z

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com®** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$1,000 per year	$2,000 per year
Family Deductible	$3,000 per year	$6,000 per year

> Member Copayments do not accumulate towards the Deductible.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$4,000 per year	$7,500 per year
Family Out-of-Pocket Maximum	$9,000 per year	$22,500 per year

> Member Copayments do not accumulate towards the Out-of-Pocket Maximum.

> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.

> The Out-of-Pocket Maximum includes the Annual Deductible.

Benefit Plan Coinsurance - The Amount We Pay		
	80% after Deductible has been met.	50% after Deductible has been met.
Maximum Policy Benefit		
The maximum amount we will pay during the entire period of time you are enrolled under the Policy.	No Maximum Benefit.	

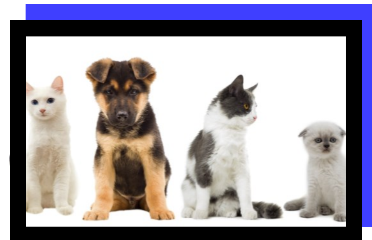
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

GAWCJG2Z07

Item#	Rev. Date	Benefit Accumulator	
200-5190	1108_rev03	Calendar Year	PVY/Sep/Emb/55373

UnitedHealthcare of Georgia, Inc. and UnitedHealthcare Insurance Company

UNDERSTANDING YOUR MEDICAL PLAN



Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Information on Benefit Limits

- The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.
- When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit Services include the diagnosis of infertility.	100% after you pay a $20 Copayment per visit.	50% after Deductible has been met.
Specialist Physician Office Visit Services include the diagnosis of infertility.	100% after you pay a $40 Copayment per visit.	50% after Deductible has been met.

- In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services

Types of Coverage	Network Benefits	Non-Network Benefits
Covered Health Services include but are not limited to:		
Primary Physician Office Visit Well child care, including periodic review of a child's physical and emotional status, is not subject to any deductible.	100% Deductible does not apply. Well child care is not subject to any deductible.	Non-Network Benefits are not available, except for well child care. Well child care is not subject to any deductible.
Specialist Physician Office Visit Well child care, including periodic review of a child's physical and emotional status, is not subject to any deductible.	100% Deductible does not apply. Well child care is not subject to any deductible.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply. Well child care is not subject to any deductible.	

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services

Types of Coverage	Network Benefits	Non-Network Benefits
	100% after you pay a $40 Copayment per visit.	50% after Deductible has been met.

- In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Scopic Procedures; Surgery; Therapeutic Treatments.

MOST COMMONLY USED BENEFITS | **YOUR BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	100% after you pay a $250 Copayment per visit.	100% after you pay a $250 Copayment per visit. *Pre-service Notification is required if results in an Inpatient Stay.*
Hospital - Inpatient Stay		
	80% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required.*

UNDERSTANDING YOUR MEDICAL PLAN

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	80% after Deductible has been met.	80% after Network Deductible has been met.
Air Ambulance	80% after Deductible has been met.	80% after Network Deductible has been met.
	Pre-service Notification is required for Non-Emergency Ambulance.	*Pre-service Notification is required for Non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	80% after Deductible has been met.	50% after Deductible has been met.
		Benefits are limited to $30,000 per surgery.
		Pre-service Notification is required.
Dental Services - Accident Only		
Benefits are limited as follows: $3,000 maximum per year $900 maximum per tooth	80% after Deductible has been met.	80% after Network Deductible has been met.
	Pre-service Notification is required.	*Pre-service Notification is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	
		Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000.
Durable Medical Equipment		
Benefits are limited as follows: $10,000 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.	80% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required for Durable Medical Equipment in excess of $1,000.*

This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: $5,000 per year and are limited to a single purchase (including repair/ replacement) every three years.	80% after Deductible has been met.	50% after Deductible has been met.

ADDITIONAL CORE BENEFITS

YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required.*
Hospice Care		
	80% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required for Inpatient stays.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	50% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met.	50% after Deductible has been met.
Ostomy Supplies		
Benefits are limited as follows: $2,500 per year	80% after Deductible has been met.	50% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	80% after Deductible has been met.	50% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met.	50% after Deductible has been met.
Pregnancy - Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
Benefits are limited as follows: $10,000 per year and are limited to a single purchase of each type of prosthetic device every three years.	80% after Deductible has been met.	50% after Deductible has been met.
This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.		
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Pre-service Notification is required.*

UNDERSTANDING YOUR MEDICAL PLAN

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of Manipulative Treatment 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy	100% after you pay a $20 Copayment per visit.	50% after Deductible has been met. *Pre-service Notification is required for certain services.*
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met.	50% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required.*
Surgery - Outpatient		
	80% after Deductible has been met.	50% after Deductible has been met.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	80% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required for certain services.*
Transplantation Services		
	80% after Deductible has been met. For Network Benefits, services must be received at a Designated Facility. *Pre-service Notification is required.*	50% after Deductible has been met. Benefits are limited to $30,000 per Transplant. *Pre-service Notification is required.*
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a $20 Copayment per visit.	Non-Network Benefits are not available.

STATE MANDATED BENEFITS

YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Pre-service Notification is required.	*Pre-service Notification is required.*
Dental Services - Anesthesia and Hospitalization		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Pre-service Notification and/or Authorization may be required as described in your Schedule of Benefits.*	
Mental Health Services		
For groups with 50 or less total employees: Benefits are limited for any combination of Mental Health and Substance Use Disorder Services as follows:	For groups with 50 or less total employees: Inpatient: 80% after Deductible has been met.	For groups with 50 or less total employees: Inpatient: 50% after Deductible has been met.
30 days per year for Inpatient 20 visits per year for Outpatient	Outpatient: 100% after you pay a $40 Copayment per visit.	Outpatient: 50% after Deductible has been met.
For groups with 51 or more total employees: Benefit limits do not apply	For groups with 51 or more total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% Deductible does not apply.	For groups with 51 or more total employees: Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.*
Neurobiological Disorders – Autism Spectrum Disorder Services		
For groups with 50 or less total employees: Benefits are limited as follows:	For groups with 50 or less total employees: Inpatient: 80% after Deductible has been met.	For groups with 50 or less total employees: Inpatient: 50% after Deductible has been met.
30 days per year for Inpatient 20 visits per year for Outpatient	Outpatient: 100% after you pay a $40 Copayment per visit.	Outpatient: 50% after Deductible has been met.
For groups with 51 or more total employees: Benefit limits do not apply	For groups with 51 or more total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% Deductible does not apply.	For groups with 51 or more total employees: Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.*

UNDERSTANDING YOUR MEDICAL PLAN

STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Substance Use Disorder Services		
For groups with 50 or less total employees: Benefits are limited for any combination of Mental Health and Substance Use Disorder Services as follows: 30 days per year for Inpatient 20 visits per year for Outpatient	For groups with 50 or less total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a $40 Copayment per visit.	For groups with 50 or less total employees: Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met.
For groups with 51 or more total employees: Benefit limits do not apply	For groups with 51 or more total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% Deductible does not apply.	For groups with 51 or more total employees: Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.*
Temporomandibular Joint Services		
Benefits are limited as follows: $3,000 per year	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Pre-service Notification is required.*

Prescription Drug Copays

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	Non-Network	Network
Tier 1	$15	$15	$37.50
Tier 2	$45	$45	$112.50
Tier 3	$65	$65	$162.50
Tier 4	$100	$100	$250

UNDERSTANDING YOUR DENTAL PLAN

DENTAL BENEFITS

UnitedHealthcare®
Voluntary Options PPO 20/covered dental services

dental plan
P1211 /MAC

	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1000 per person per calendar year	$1000 per person per calendar year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	12 months for major services	

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations *(Amalgam or Anterior Composite)**	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services *(including Emergency Treatment)*	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary. Occlusal Guard: Limited to 1 guard every consecutive 36 months.
MAJOR DENTAL SERVICES			
Simple Extractions	50%	50%	Limited to 1 time per tooth per lifetime.
Oral Surgery *(includes surgical extractions)*	50%	50%	
Periodontics	50%	50%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.

Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

** The network percentage of benefits is based on the discounted fee negotiated with the provider.
*** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.
In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Voluntary Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York;
Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United Healthcare Services, Inc.

UNDERSTANDING YOUR VISION PLAN

VISION BENEFITS

Vision Benefit Summary
www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan V0008

	NETWORK	NON-NETWORK
Comprehensive Vision Exam	$10 Copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$25 Copay[1]	See below
Frequencies - Based on last date of service	Exam Once every 12 months Lenses Once every 12 months Frames Once every 24 months	

COVERED SERVICES	NETWORK	NON-NETWORK
Pair of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay[1] Includes standard scratch-resistant coating	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a $50 wholesale frame allowance (approximate retail value of $120-$150) at our private practice providers; or a $130 retail frame allowance at our retail chain providers. For frames which exceed the allowance, you may receive an additional 30% discount, available only at participating providers.	Up to $50 wholesale/$130 retail frame allowance (after applicable copay [1])	Up to $45
Contact Lenses[2]		
• Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting our website www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay [1])	Up to $105
• Non-selection contacts You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $105 (material copay is waived)	Up to $105
• Necessary contact lenses[4]	Covered in full after applicable copay[1]	Up to $210

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneals/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Group Term Life Insurance

Evans Animal Hospital provides you with the benefits to take care of your loved ones when you're gone.

Evans Animal Hospital provides a life insurance policy for each employee in the amount of $15,000 and an AD&D life policy in the amount of $15,000

Premium Only Flex Plan

Evans Animal Hospital offers a Premium Only Flex plan that enables you to pay for your portion of the premiums with pre-tax dollars, reducing your taxable income. Examples of the savings are listed on the chart below:

	Without a Flex Plan	With A Flex Plan
Income	$40,000	$40,000
Premium	$0	$2,000
Tax Deduction (35% est.)	$14,000	$13,300
After Tax Income	$26,000	$26,700
Increase in take home pay	$0	$700

2017 Health Plan Notices

⋆ Michelle's Law

All group health plans must allow a college student with a "serious illness or injury" to remain eligible for active dependent coverage for 12 months, even if he or she no longer qualifies as a full-time student. The law applies to both insured and self-insured health plans.

The specific requirements are:

- The individual must be covered as a full-time student, as defined in the plan, at a postsecondary educational institution immediately before any serious illness or injury occurs.
- The student must experience a "serious illness or injury" that requires a medically necessary leave of absence or a medically necessary change in enrollment status from full-time to part-time. The term "serious illness or injury" is not defined.
- A physician must verify the illness or injury in writing and certify the leave of absence or change in enrollment status as medically necessary. The law does not contain a deadline by which this information must be provided.
- The health plan must allow the student to remain covered as an active participant/dependent for 12 months after the leave of absence begins. The regular premium will apply during these 12 months.
  The 12 months, however, does not extend coverage beyond another independent event that would end active/dependent status, such as the parent's termination of employment or the student exceeding the plan's age limit.
  - COBRA coverage would not be offered until after the 12-month special period has expired, unless the student returns to full-time status and remains eligible under other terms of the plan.

⋆ HIPAA Notice of Privacy Practices Reminder Notice

The HIPAA Privacy Rule was originally effective on April 14, 2003. This rule required health plans to send participants an initial notice of privacy practices and then reminders must be given once every three years. This memo is a reminder that if you would like to see or obtain another copy of the health plan's HIPAA Privacy Notice, please contact Human Resources.

⋆ Women's Health and Cancer Rights Act of 1998

"Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema").

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

★ The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

Important Notice from Evans Animal Hospital About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Evans Animal Hospital and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Evan's Animal Hospital has determined that the prescription drug coverage offered by the Group Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Evans Animal Hospital coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Evans Animal Hospital coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Evans Animal Hospital and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information you may call Amy Rydzinski at 706-868-0479. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Evans Animal Hospital changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	April 2017
Name of Entity/Sender:	Evans Animal Hospital
Contact--Position/Office:	Amy Forsha
Address:	4317 Evans to Lock Rd, Evans, GA 30809
Phone Number:	706-868-0479

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

MANDATED NOTICES

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

MANDATED NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

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 Amy Forsha 706-868-0479.

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)
Evans Animal Hospital			26-0748646
5. Employer address			6. Employer phone number
4317 Evans To Lock Rd			715-235-0316
7. City	8. State	9. ZIP code	
Evans	GA	30809	
10. Who can we contact about employee health coverage at this job?			
Amy Forsha			
11. Phone number (if different from above)	12. Email address		
706-868-0479	amy@evansanimalhospital.net		

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

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full time employees averaging 30 hours or more per week

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal spouses and children up to age 26

  - [ ] 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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, 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 dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name ___________________________ ☐ Dependent has other coverage ☐ Another reason

Name ___________________________ ☐ Dependent has other coverage ☐ Another reason

Name ___________________________ ☐ Dependent has other coverage ☐ Another reason

Name ___________________________ ☐ Dependent has other coverage ☐ Another reason

______________________________________ ______________________________________

Employee Name – Please Print Employee Social Security Number

______________________________________ _________/__________/_________

Employee Signature **Date**

Notes

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Evans Animal Hospital Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Evans Animal Hospital retains the right to modify or eliminate these benefits at any time and for any reason.