
Switchpoint Family
Welcome
To Open Enrollment

OPEN ENROLLMENT

is a short period of time each year when employees may elect or change the benefit options available through their employer, such as health, dental and life insurance, etc.

WHO IS ELIGIBLE?

ALL Full-Time employees that work 30+ hours per week

WHEN TO ENROLL?

NOV 15 to DEC 2

Marriage/Divorce
Birth/Adoption
Loss of Coverage, etc.

NOTIFY HR within 30-Days

WELCOME TO OPEN ENROLLMENT

switchpoint™

Plan Year: 2023

WHAT YOU NEED TO KNOW

HOW TO ENROLL

CONTRIBUTIONS & COSTS

HEALTH INSURANCE H.S.A.

PROGRAMS TO SAVE $

MOTIVHEALTH ACCOUNTS

OTHER BENEFITS

SWITCHPOINT I.R.A.

DEADLINE TO ENROLL

employee NAVIGATOR

Website - www.employeenavigator.com

EVERY Full-Time Employee MUST Create an Account and MUST either ENROLL or DECLINE the OFFERED COVERAGE during OPEN ENROLLMENT or NEW HIRE Window.

Company Identifier

FriofSwi2022

YOU CAN...

- **Enroll in coverage**
- **Update Benefits throughout the year**
- **Access Benefit Information**
- **Access/Update Contact Information**

- Existing Users – **Log into your Account**
- New Users: Create your **username** and **password**
- Once you are registered, begin by clicking on the green Start Enrollment Button
- **Enroll** or **Decline** each benefit. Be sure to click Save & Continue at the bottom of each screen
- **The last page will show you your elections and per paycheck costs**. You can go back and change your elections by clicking on **view steps** on the right-hand side of the screen
- Once you are satisfied with your elections, click the green Click to Sign button in the box at the center of the page

YOU'RE A LUCKY DUCK!!

Switchpoint pays 100% of each Employee's Health Insurance premium and 50% of Spouses and dependents.

WE'RE PUTTING $50 PAYCHECK

$1300/YR

SWITCHPOINT CONTRIBUTION

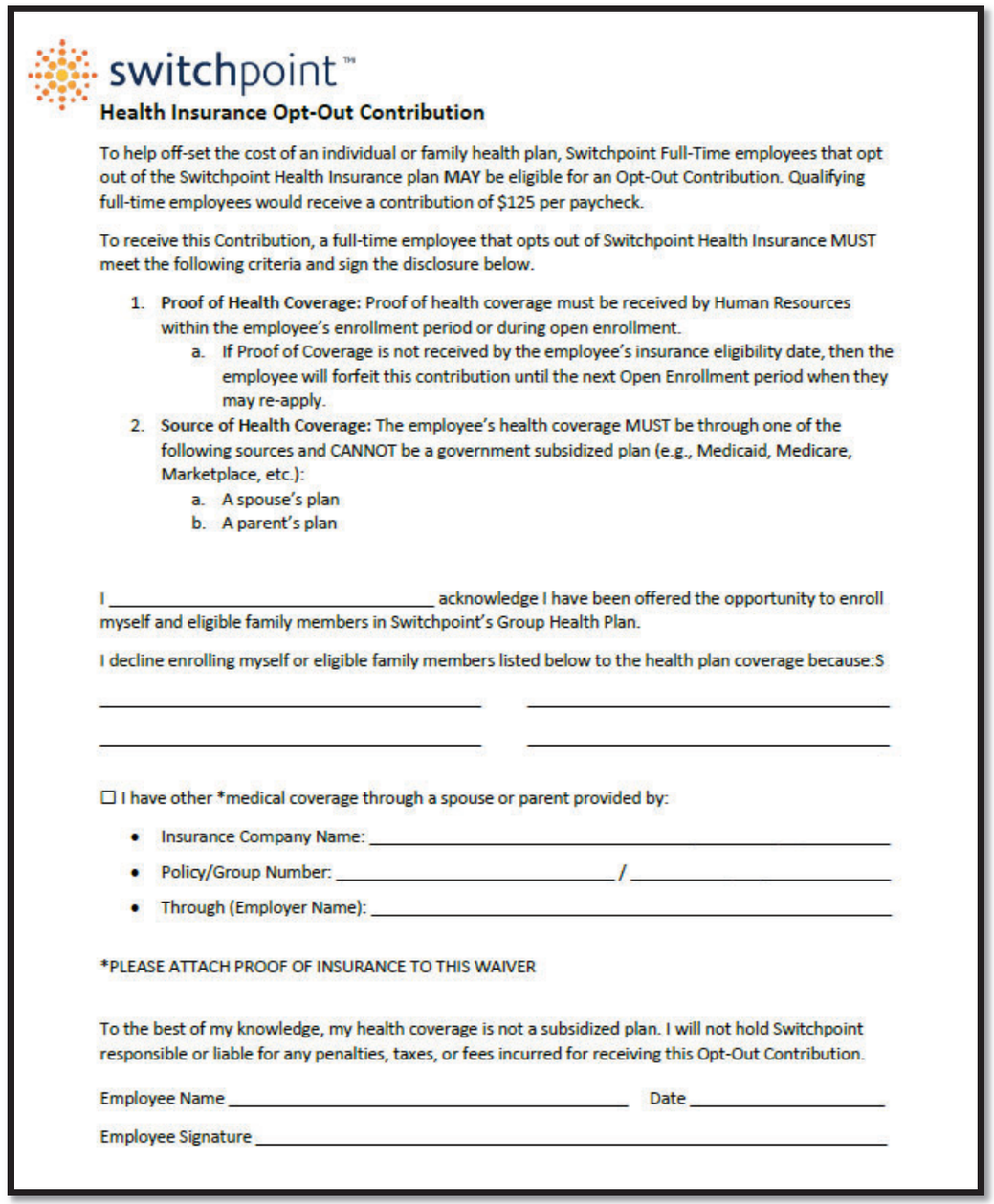
Benefit	Plan	Coverage	Total Monthly Premium	Employer Monthly Contribution	Your Per Paycheck Contribution
Medical MotivHealth	H S A $2,000 Wise Network	Single	$565.02	$565.02	$0.00
		Employee + Spouse	$1,243.16	$904.09	$156.49
		Employee + Children	$1,130.03	$847.52	$130.39
		Family	$1,525.61	$1,045.31	$221.67

YOUR CONTRIBUTION

Benefit	Plan	Coverage	Total Monthly Premium	Employer Monthly Contribution	Your Per Paycheck Contribution
Medical MotivHealth	H S A $2,000 Wise Network	Single Employee + Spouse Employee + Children Family	$565.02 $1,243.16 $1,130.03 $1,525.61	$565.02 $904.09 $847.52 $1,045.31	$0.00 $156.49 $130.39 $221.67

OPT-OUT CONTRIBUTION

- **Full-Time employees that decline health insurance because they are covered under a spouse or parents QUALIFYING plan, may be eligible to receive a $125/paycheck Opt-Out Contribution.**
- **This contribution will begin no sooner than the month the employee is eligible for insurance, Opt-Out Contribution form + Proof of Insurance is submitted to HR/Payroll.**



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Health Insurance Opt-Out Contribution

To help off-set the cost of an individual or family health plan, Switchpoint Full-Time employees that opt out of the Switchpoint Health Insurance plan **MAY** be eligible for an Opt-Out Contribution. Qualifying full-time employees would receive a contribution of $125 per paycheck.

To receive this Contribution, a full-time employee that opts out of Switchpoint Health Insurance MUST meet the following criteria and sign the disclosure below.

1. **Proof of Health Coverage:** Proof of health coverage must be received by Human Resources within the employee's enrollment period or during open enrollment.
   a. If Proof of Coverage is not received by the employee's insurance eligibility date, then the employee will forfeit this contribution until the next Open Enrollment period when they may re-apply.
2. **Source of Health Coverage:** The employee's health coverage MUST be through one of the following sources and CANNOT be a government subsidized plan (e.g., Medicaid, Medicare, Marketplace, etc.):
   a. A spouse's plan
   b. A parent's plan

I _____ acknowledge I have been offered the opportunity to enroll myself and eligible family members in Switchpoint's Group Health Plan.

I decline enrolling myself or eligible family members listed below to the health plan coverage because:S

_____ _____

_____ _____

☐ I have other *medical coverage through a spouse or parent provided by:

- Insurance Company Name: _____
- Policy/Group Number: _____ / _____
- Through (Employer Name): _____

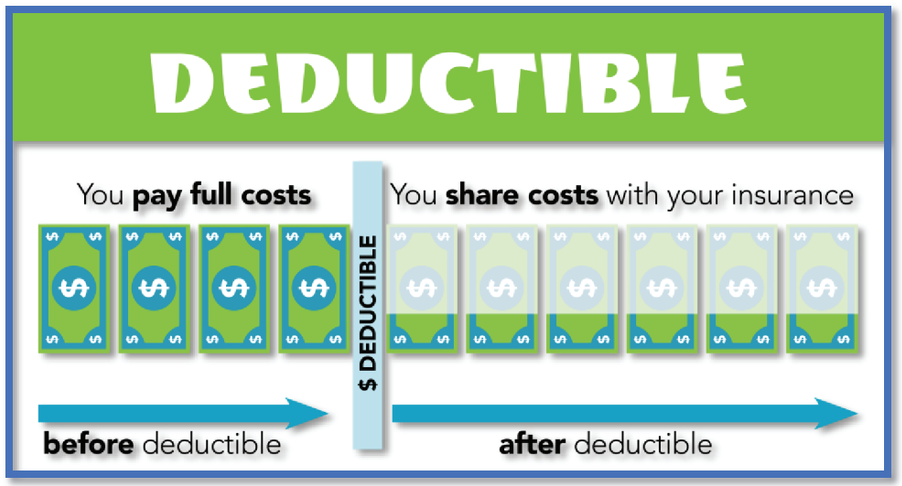
*PLEASE ATTACH PROOF OF INSURANCE TO THIS WAIVER

To the best of my knowledge, my health coverage is not a subsidized plan. I will not hold Switchpoint responsible or liable for any penalties, taxes, or fees incurred for receiving this Opt-Out Contribution.

Employee Name _____ Date _____

Employee Signature _____

HSA 2000



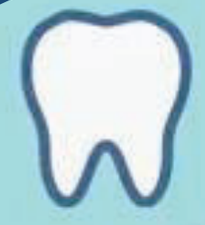
Benefits	In Network	Out of Network*
Deductible Individual / Family	$2,000 or $4,000	$4,000 or $8,000
Out-of-Pocket Maximum Individual / Family	$5,000 or $10,000 Embedded	$10,000 or $20,000 Embedded
Telemedicine	$0	No Benefit
Preventive Care	Covered 100%	40%[AD]
Office Visit Primary Care / Specialist	20% [AD]	40%[AD]
Urgent Care	20% [AD]	40%[AD]
Wellness Rewards	$20 per Month up to $250/Year Enrolled Employee and Enrolled Spouse	
Outpatient Services	20%[AD]	40%[AD]
Inpatient Services	20%[AD]	40%[AD]
Emergency Room	20%[AD]	
Mental Health / Substance Abuse	20% AD	40% AD
Prescriptions Tier 1 Tier 2 Tier 3	20% AD	40% AD
Provider Search: www.motivhealth.com Member Services: 844-234-4472		

AD = After Deductible

DEDUCTIBLES & CO-INSURANCE

PRESCRIPTIONS

DENTAL & GLASSES



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HSA

HEALTH SAVINGS ACCOUNT

DEBIT CARD for MEDICAL EXPENSES

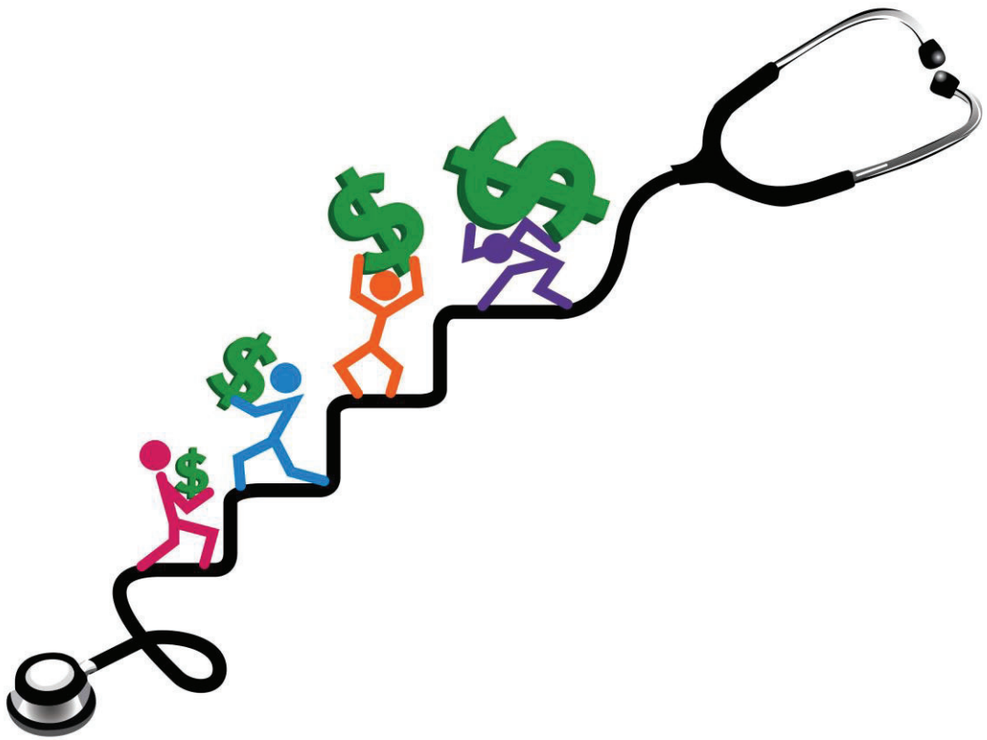
2021 HSA Contribution limits

Individual: $3850
Family: $7750
55+ yrs: +$1000

You may want to consider contributing additional money each month into your HSA – TAX FREE!!

All money in the Account is yours to KEEP. Any dollars that you don't spend stay in your account and will grow from year to year

We need your help to keep Healthcare costs down ⇩



⇧

Instead of Rising?

USE THE TELEHEALTH APP

With HealthiestYou you can connect to a doctor, get treatment, and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more sitting around in waiting rooms. And best of all, it's **FREE!!**

$0 = FREE

SmartPay
Same-Day Discount Program

When our members choose to have certain planned medical procedures performed by our high-value providers, and pay in advance, we can reduce member out-of-pocket expenses between **$250-$3000**.

HOW TO PARTICIPATE

1. **Call Us**
   Call our Personal Health Assistants (844-234-4472) prior to scheduling a planned medical procedure.
2. **Choose Care**
   Choose a preferred high value provider.
3. **Pay Reduced Fee**
   Pay your reduced cost in advance.
4. **Get Care**
   Receive the medical care you need.

Pay Less
Lower your out-of-pocket expense.

Get Rewarded
Save extra for being a savvy healthcare consumer.

Get Excellent Care
Receive treatment from high value providers.

PRESCRIPTION ASSISTANCE

Spending $200+/month on Medicines?
You will want to participate in this program!!

DIABETES PATIENT CARE

You or a family member has Diabetes?
FREE Testing Supplies!! + Insulin at LOWER Cost!

Steps Incentive Program

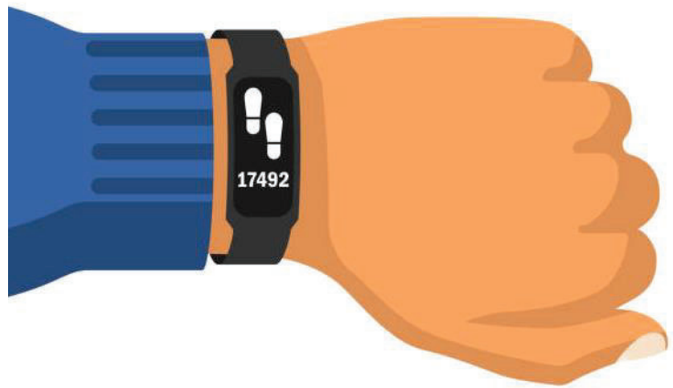
Sync your Fitbit, pedometer or Apple Watch to MotivHealth

8,000 Steps

20 Days a month

= $250/Year into HSA

$500 is spouse participates too!



PROGRAMS

PROMPT

SAVE YOU MONEY AND ALLOW US TO KEEP COSTS DOWN ⇩

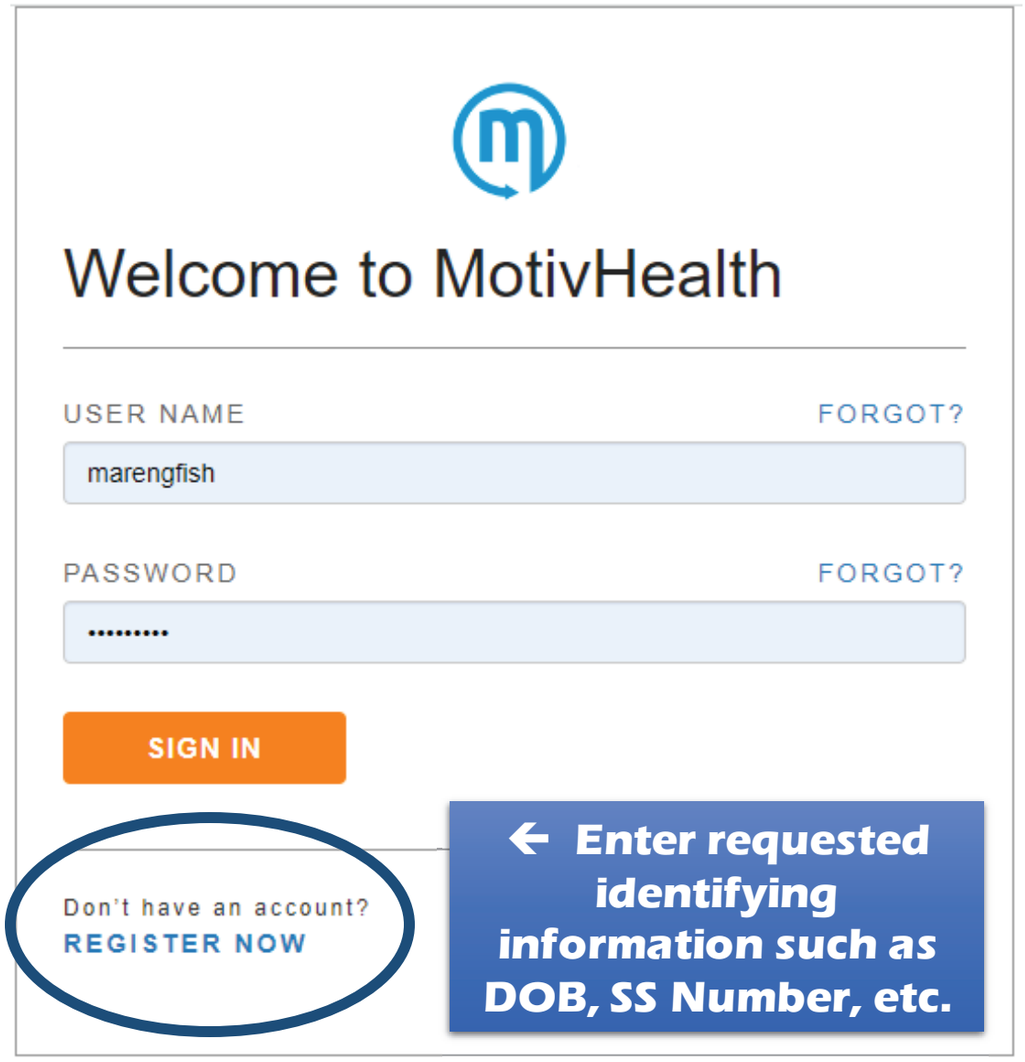
your phone! Download the app!

motivhealth®

https://www.motivhealth.com/ LOGIN

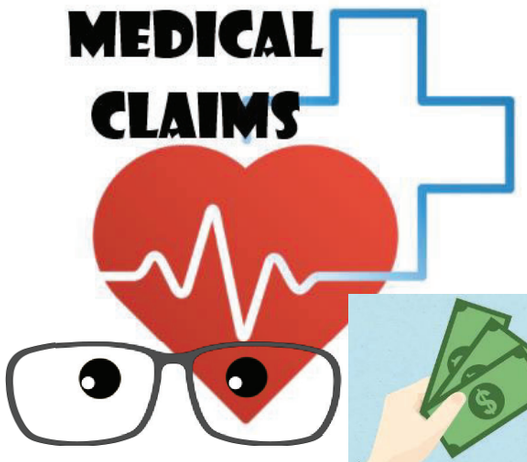
WHO: Needs to Register and Set Up an Account??

Due to Medical Privacy Laws each covered member 18+ years NEEDS their OWN ACCOUNT to view Full Information

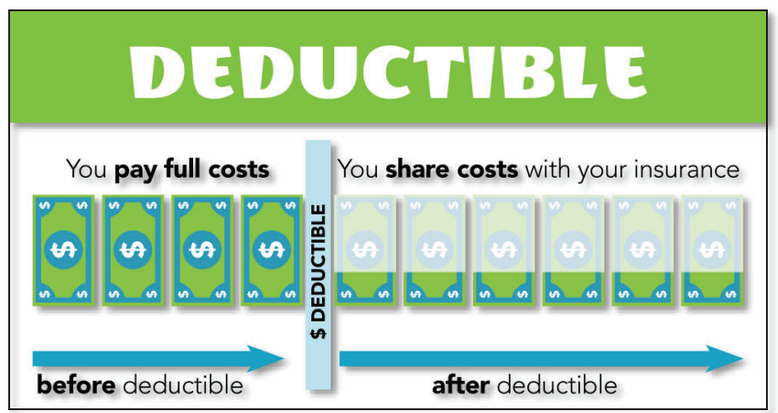


YOU, SPOUSE, 18+ DEPENDENTS

motivhealth®



EARN $50
IN 60
motivU



OTHER INSURANCE OFFERED THROUGH

MetLife®

...Will be an "Out of Pocket" Expense

USE IN-NETWORK PROVIDERS
No Insurance Card Needed
Just DOB and SS Number

Statement of Health

INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

INSTRUCTIONS TO THE EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee's Spouse/Domestic Partner or the Employee's Child.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.

For QUESTIONS, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at LMSOH@metlifeservice.com.

Metropolitan Life Insurance Company,
Medical Underwriting
P.O. Box 14593
Lexington, KY 40512-4593
FAX: 1-888-505-7446
To submit by Email:
METLIFESOH@metlife.com

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer.

These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

Send SOH forms to HR or Directly to Karen Hawks

Leavitt Group
Dixie Leavitt Agency

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

NEEDED FOR:

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

	Yes	No
1. Your height ___ feet ___ inches Your weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
If "yes", provide Physician's name _____ Telephone: (____) ____ – _____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐	☐
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified or ☐ issued other than as applied for? Indicate reason _____	☐	☐

$WITCHPOINT I.R.A. PROGRAM

SIGN UP

CONTACT H.R. FOR NECESSARY PAPERWORK AND TO HELP FACILITATE

BRENT SHAKESPEARE

RAYMOND JAMES™

FINANCIAL, INC.

- **Employees may deposit their own funds through payroll deductions.**
- **Switchpoint will match up to 3%**
- **Personal contributions will be deposited into the IRA plan each pay period.**

OPEN ENROLLMENT ENDS

FRIDAY

Leavitt Group

Dixie Leavitt Agency

ACCOUNT MANAGER

Karen Hawks

435-216-5321

ADVISOR

Austin Guymon

435-862-0149