City of Akron Spousal Provision Form Benefit Year 2027

This form is required each enrollment period and after a qualifying event for active employees who cover a spouse on the medical/prescription plan.
Please complete and upload the Spousal Provision Form to Workday by December 10, 2026.
Do <u>not</u> complete this form if you do not have a spouse or your spouse is not enrolled on the medical/prescription plan.

EMPLOYEE AND SPOUSE TO COMPLETE AND CERTIFY *(please print clearly)*

City of Akron Employee Name:	**Employee ID#:**	
Spouse Name ("Spouse"):	**Effective date of qualifying event:**	**January 1, 2027**
Preferred Employee Contact #:		

My spouse is (check only one box under Section A OR Section B):

SECTION A (check only one box)

☐ Not employed	☐ Self-Employed (no health care)	☐ Retired (*not* working)	☐ City of Akron employee

☐ My spouse is enrolled in his/her employer's health plan as primary, and I wish to elect **<u>SECONDARY</u>** medical coverage for my spouse through the City of Akron.

Skip Section B if you checked a box above. Employee and Spouse sign below and return the form to Employee Benefits. No other information is required.

OR

SECTION B (check only one box)

☐ My spouse is employed and is <u>not</u> enrolled in his/her employer's health plan. I understand that if my spouse's employer coverage does not meet the waiver criteria I will have a $150 monthly spousal surcharge deducted from my paycheck. ***If you wish to have primary coverage for your spouse through the City of Akron, sign below and have your spouse's employer complete the Spouse's Employer Certification of Coverage (Page 2). Completed forms should be returned to Employee Benefits.***

☐ My spouse is employed. *I will **not** be submitting the Spouse's Employer Certification of Coverage for review.* I understand I will have a $150 monthly spousal surcharge deducted from my paycheck. ***If you wish to have primary coverage for your spouse through the City of Akron, sign below and return the form to Employee Benefits.***

I UNDERSTAND AND CERTIFY:

I am lawfully married and the information provided on this certification form is accurate and truthful. I must notify the City of Akron within 31 days of a qualifying event permissible under Section 125 of the Internal Revenue Code (i.e.: marriage, divorce, become eligible for coverage elsewhere, unpaid leave of absence, and change in work status). I understand that if I fail to notify the City of Akron of my change in eligibility status, this may constitute fraud and I may be subject to consequences including, but not limited to, disciplinary action, up to and including termination of employment, and reimbursing the City for expenses paid and other expenses plus interest while not eligible under the plan. I am personally liable for any benefits paid should any of the information provided be inaccurate. My signature below certifies that all the information provided on this form is correct to the best of my knowledge, and **that it is my responsibility to ensure the City of Akron Employee Benefits Division receives the completed form from my spouse's employer, if applicable, as well as the information and documentation needed to determine waiver eligibility.**

If I am subject to the surcharge, by signing below, I authorize payroll deductions to be made on a pre-tax basis and acknowledge that, under Section 125 of the Internal Revenue Code, pre-tax deductions cannot be revoked or changed unless a qualifying event occurs and the change is consistent with the qualifying event. Pre-tax coverage remains in effect until a new authorization to start, change, or cancel coverage, subject to contract provisions, Section 125 of the Internal Revenue Code, and City policies is submitted and processed by Employee Benefits. If I am in an unpaid status, I agree to submit payment to the City of Akron in order to continue coverage. I understand if I fail to submit required payments, coverage will be terminated.

REQUIRED ATTACHMENTS (check all that apply to your situation):

- ☐ Not applicable — Section A completed; no further documents required
- ☐ Spouse's Employer Certification of Coverage (Page 2)
- ☐ HSA/HRA employer contribution information (if offered)
- ☐ Summary of Benefits & Coverage (SBC) for all of spouse's employer plans
- ☐ Spouse's employee contribution rate sheet (all plans)

I understand this form is not considered complete, and my spousal coverage election cannot be processed, until all required supporting documentation identified above is received by Employee Benefits. Incomplete submissions received by the deadline will default to the $150 monthly spousal surcharge.

Employee Signature: _____ **Date:** _____

Employee's Spouse Signature: _____ **Date:** _____

A physical (handwritten) signature is required on Page 1 and Page 2. Digital or typed signatures will not be accepted. This means:

- Digital or typed signatures (e.g., typed name in script font, Adobe/DocuSign e-signatures, or simple text entry) will **<u>not</u>** be accepted.
- A scanned or imaged copy of a handwritten signature is acceptable if the original form cannot be turned in.
- This requirement is in place to ensure compliance during eligibility audits and reduce the risk of disputes regarding spousal coverage elections.

As a backup, and in alignment with legal practice in Ohio courts, the "/s/[Name]" signature format may be accepted in limited circumstances where obtaining or scanning a handwritten signature presents difficulty.

SPOUSE'S EMPLOYER CERTIFICATION OF COVERAGE

This form is required each enrollment period and after a qualifying event for employees who cover a spouse on the medical/prescription plan.

EMPLOYEE AND SPOUSE TO COMPLETE (please print clearly)

City of Akron Employee Name:	**Employee ID#:**
Spouse Name ("Spouse"):	

SPOUSE'S EMPLOYER TO COMPLETE AND CERTIFY (please print clearly)

Company Representative Name:	**Preferred Contact #:**
Company Name:	**Preferred Email:**

I, _____ ("Spouse's Company Representative Name"), do hereby acknowledge that the above "Spouse" is currently an employee of _____ ("Spouse's Company Name").

OUR COMPANY CURRENTLY (SELECT ALL THAT APPLY):

☐ **A.** Does not offer any employer-sponsored healthcare plan at this time.

☐ **B.** Offers an employer-sponsored healthcare plan, but the above-named "Spouse" does not qualify to participate in the plan[1] for the following reason:

_____

☐ **C.** Offers an employer-sponsored healthcare plan, and the above-named "Spouse" currently qualifies to participate and is eligible for benefits. Regardless of whether "Spouse" is currently enrolled, please attach the following documents:

- All SBCs[2] (Summary of Benefits & Coverage) as required by the ACA
- All employee health premium contribution rates
- Attached employee contribution rates are per: ☐ 12 pays ☐ 24 pays ☐ 26 pays ☐ 52 pays
- If an HSA or HRA plan option is offered, complete Section D

☐ **D.** Offers an HSA or HRA plan option. Regardless of whether "Spouse" is currently enrolled, please provide the standard annual employer contribution for single (employee-only) coverage:

Account		Annual Contribution	Plan Name
Health Savings Account (HSA)	☐ N/A	$ _____	_____
Health Reimbursement Account (HRA)	☐ N/A	$ _____	_____
Flexible Spending Account (FSA)	☐ N/A	$ _____	_____

If contributions differ by plan, list each plan separately. Attach a separate sheet if more space is needed.

Healthcare Insurance Carrier's Name (if applicable):

Number of employer-sponsored healthcare plans offered:

Date of Open Enrollment and Effective Date of Benefits[1]:

ACKNOWLEDGEMENTS

I do hereby attest that the above information is complete and accurate to the best of my knowledge.

Spouse's Employer's Signature: _____ **Date:** _____

By signing, I authorize my employer or my health insurance carrier to disclose information to the City of Akron to verify the representations made on the Spouse's Employer Certification of Coverage.

Spouse's Signature: _____ **Date:** _____

A physical (handwritten) signature is required on Page 1 and Page 2. Digital or typed signatures will not be accepted. This means:

- Digital or typed signatures (e.g., typed name in script font, Adobe/DocuSign e-signatures, or simple text entry) will **not** be accepted.
- A scanned or imaged copy of a handwritten signature is acceptable if the original form cannot be turned in.
- This requirement is in place to ensure compliance during eligibility audits and reduce the risk of disputes regarding spousal coverage elections.

As a backup, and in alignment with legal practice in Ohio courts, the "/s/[Name]" signature format may be accepted in limited circumstances where obtaining or scanning a handwritten signature presents difficulty.

[1] If qualification is due to Section 125 of the Internal Revenue Code provisions, please attach Section 125 documentation.
[2] If employer offers more than one healthcare plan, please attach all SBCs and contributions by plan.

City of Akron Spousal Provision Information Sheet

Spouses of City of Akron employees who are covered on the City's Medical/Prescription benefit and who are eligible for health insurance coverage from their own employer must enroll in that coverage effective January 1, 2027 and thereafter, or the employee may be subject to a $150 monthly spousal surcharge for the spouse to remain on the City of Akron Medical/Prescription plan as primary. If a spouse enrolls in his/her employer's health plan, he/she may remain on the City of Akron Medical plan as secondary and not have to pay the $150 monthly spousal surcharge. The City does not coordinate secondary on prescriptions.

ACTION NEEDED during this Open Enrollment:

Employee must complete and upload the Spousal Provision Form to Workday by December 10, 2026. If the spouse is working and not enrolled in his/her employer's plan, the spouse must provide a completed and signed Spouse's Employer Certification of Coverage and must submit all plan designs, all employee contributions, and any employer contributions. Incomplete submissions received by the deadline will default to the $150 monthly spousal surcharge.

Situations when the surcharge would apply due to your spouse not enrolling in his/her employer's plan:

- Employee does not return the Spousal Provision Form.
- Employee returns the Spousal Provision Form without the required supporting documentation.
- Spouse is offered employer-sponsored coverage that does not meet the waiver criteria, and spouse does not elect that coverage and remains on the City of Akron plan as primary.

Situations when the surcharge would not apply (waiver criteria):

- The spouse does not work, or works but is not offered/not eligible for benefits.
- The spouse has primary coverage at his/her place of employment and is enrolled in the City of Akron plan as a dependent, with the City's plan providing coverage on a secondary coordination of benefits basis (Medical only). Employee will be required to pay the family rate, and the birthday rule will apply for dependent child(ren), if they are eligible dependents.
- A spouse whose employer charges monthly single contributions greater than or equal to $150 per month can remain on the City's plan without the surcharge. If the employer offers multiple plans with lower contributions, then the $150 spousal surcharge would apply regardless of the plan the spouse elected.
- A spouse whose employer's net single deductible is greater than or equal to $1,000 a year can remain on the City's plan without the surcharge. If the employer offers multiple plans with a net deductible lower than $1,000, then the $150 spousal surcharge would apply. Proper documentation from the spouse's employer is required (see Spouse's Employer Certification of Coverage form).

  Net Deductible Example: *If an employer offers a $2,000 High Deductible HSA plan but contributes $1,500 to help cover the cost of the deductible, then the net deductible is $500. In this scenario, the spouse would have to pay a surcharge to remain on the City's plan as primary.*
- The spouse provision is not intended to apply to retired spouses of City employees.

Additional Information

- Coordination of Benefits applies to Medical only. There is no secondary coverage for Prescriptions.
- Dental deductibles, vision deductibles, and voluntary HSA contributions do not count toward the criteria.
- If you are self-employed and/or a business owner and you offer an employer-sponsored health plan to your employees, the spousal provision criteria will apply.
- If a spouse experiences a qualifying event that results in a loss of coverage at his/her place of employment permissible under Section 125 of the Internal Revenue Code, the spouse may enroll in the City of Akron medical/prescription plan and the surcharge will not apply. Examples of qualifying events may include, but are not necessarily limited to:
  - Reduction in work hours, termination of employment, or a strike or lockout resulting in loss of coverage;
  - Commencement of an unpaid leave of absence;
  - A change in worksite or place of residence of the spouse.

Should the spouse gain employment or access to his/her employer health plan during the plan year, the City of Akron Employee Benefits Office must be notified within 31 days of the available coverage. If the newly available coverage meets the criteria for the spousal surcharge, the employee will be subject to the surcharge if the spouse chooses not to elect his/her employer coverage.

If an employee fails to notify the City of Akron Employee Benefits Office of a change in his/her spouse's eligibility status, this may constitute fraud and may be subject to consequences including, but not limited to, reimbursing the City for expenses paid while not eligible under the plan.