ILENE SHAPIRO
COUNTY EXECUTIVE

2023 OPEN ENROLLMENT GUIDE

COUNTY OF SUMMIT

OPEN ENROLLMENT
for 2023 Benefits

October 31 through
November 14, 2022

Benefits Effective Date
January 1, 2023

For more information about the 2023 benefits,
go to *HREB.summitoh.net*.

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Please note, this guide and our web resources are not intended to take the place of any plan document. If there is ever a conflict between this guide and the plan documents, the plan documents will govern. The Department of Human Resources, Division of Employee Benefits maintains the Summary Plan Descriptions (SPD's) which contain more detailed information. These may be found on the new Employee Benefits website (HREB.summitoh.net) if you wish to print a hard copy.

The County of Summit reserves the right to modify, amend or terminate any or all of these benefits at any time for any reason.

WELCOME
BENEFITS MENU | ENROLLMENT

BENEFITS OFFERED

MY HEALTH
Medical | **Medical Mutual of Ohio**
Prescription | **Express Scripts**
Dental | **Guardian Dental**
Vision | **Davis Vision**
FSA, HRA, HSA, COBRA | **TASC**

MY LIFE
Life and AD&D | **Guardian Life**
Voluntary Life | **Guardian Life**

MY EXTRAS
Wellness | **Virgin Pulse**
Telemedicine | **First Stop Health**
Employee Assistance (EAP) | **EASE@Work**
Voluntary Benefits l **AFLAC/Trustmark**
Benefits Decision Tool l **Nayya**

Coordination of Benefits (COB)
Individuals who are covered under another benefit plan will have their benefits coordinated. The benefits you have with your employer are primary (pay first) and the benefits in which you are covered as a dependent pay secondary after the primary insurer. (Vision benefits do not coordinate.)

Your Open Enrollment Period
October 31st - November 14th
(Benefits Effective January 1, 2023 thru December 31, 2023)

Each year, as the County of Summit evaluates the employee benefit plans, it remains our intention to provide you and your families with a high level of benefits at an affordable cost. Please take time to review your benefit options so you may select the coverage that best meets your financial and health care needs.

2023 CHANGES:

1. MedFlex Plan deductible decrease to $500 single/$1,000 Family.
2. MedFlex is the default plan if open enrollment is not completed.
3. HSA Employer Contribution for 2023 of $1,000 single /$2,000 Family.
4. HSA Employee Annual Contribution limit increase to $3,850 single /$7,750 Family.
5. Advantage Plan in network deductible increase to $1,000 single /$2,000 Family with 80%/20% coinsurance.
6. Health Care FSA increase to Maximum Annual Contribution to $3,050.
7. Addition of new drug program “SaveonSP”.
8. Addition of new Employee Benefits Support Tool, Nayya.

Should you have any questions about these benefits, please contact the Employee Benefits Department at (330) 643-5551. Please leave a message including your contact information and an Employee Benefits Team member will return your call.

Additional information to remember when completing the Enrollment process:
Review and update as needed all demographic and emergency contact information. **All full and part-time employees will need to confirm they have received the Fraud Hotline information provided by Internal Audit through the online enrollment process as well as signing the annual Fitness Waiver.**

All full-time employees **MUST** enroll through the BenXpress System in order to have benefits in 2023. If you are enrolled in the Advantage, Maximum Value or the Minimum Value plans and you do not enroll through the online system, you will default to the MedFlex plan for 2023 plan year. If you currently waive the benefit plan and you do not enroll through the BenXpress system for the 2023 plan year, your benefits will be waived and you will no longer receive the $50 monthly health waiver.

ELIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 35 hours per week. Your coverage will be effective on the 1st of the month following your date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or **dependent child(ren)** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage and when coverage terminates under each benefit plan type:

LINE OF COVERAGE	WHEN COVERAGE ENDS
New Hires	Date of Termination or Loss of Full-Time Status
Medical/Rx, Vision, Dental, Life	Employee/Spouse - Date of Termination or Loss of Full-Time Status; Child(ren) – The last day of the month the dependent turns 26
Child Life Insurance	The last day of the month the dependent turns age 26
Spouses are Eligible for:	Medical/Rx, dental, vision, spousal life

QUALIFYING LIFE EVENTS

If you have a Qualifying Life Event you MUST notify your benefit coordinator to complete your online election changes within 30 days following the event date. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Death of a Dependent, Loss/Gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' located on the Employee Benefits Website.

IMPORTANT

You may not make changes to these elections during the year unless you experience a qualified life event, which must be reported to your Benefit Coordinator within 30 days of the event.

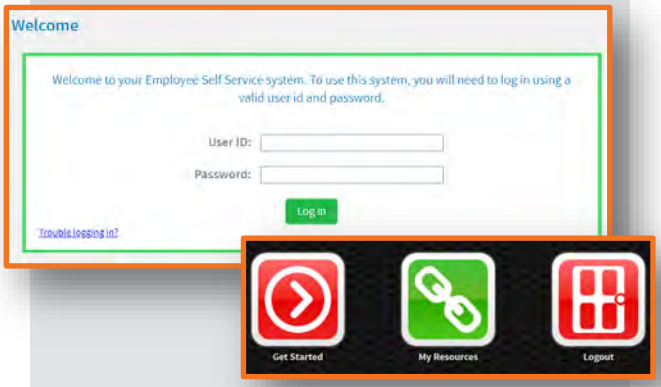
If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA continuation details can be found in the notices section of this employee benefit guide.

ENROLLMENT INSTRUCTIONS
OPEN ENROLLMENT GUIDE

ONLINE ENROLLMENT THROUGH BENXPRESS

To start the enrollment process, click on "Get Started" at the Welcome screen. The Welcome screen will display a "Hints" section to help you navigate through all sections.

Please note, if you do not click on the SAVE Elections icon, your elections will not be saved and you will not be enrolled in the benefits you elected.



Your Open Enrollment Period
October 31st - November 14th

All employees have access to our online benefits enrollment platform 24/7 where you have the ability to enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

- ✓ Accessible 24/7;
- ✓ View all benefit plan options and your elections;
- ✓ View important carrier forms and links;
- ✓ Report a qualifying life event; and
- ✓ Make changes to beneficiary designations and more.

ENROLLMENT INSTRUCTIONS:

1. Go To: *https://www.benxpress.com/summit*
2. Username: First Initial and Last Name/Last 4 of SSN (Example: jdoe1234)
3. Password: First Name and Birth Year(YYYY) (Example: john1967)

This is a required enrollment: If you do not take action by November 14, 2022, you will be enrolled in the MedFlex Plan (narrow provider network), and you must wait until the next open enrollment period or a qualifying life event to make changes to your benefit plan.

READY TO ENROLL? GO TO: *https://www.benxpress.com/summit*

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

DECISION ASSISTANCE
NAYYA

Selecting Your Benefits
USER GUIDE

Nayya Choose, a data-driven decision support platform, is designed to guide you through open enrollment with personalized insights so you can feel more confident in your benefits decisions.

Nayya The support you deserve while you **select your health and wellness benefits**

HOW DOES IT WORK?
Nayya walks you through a quick, step-by-step assessment to determine the right level of coverage based on your unique needs. With Nayya, you can complete an enrollment assessment in less than 10 minutes to obtain a benefit recommendation!

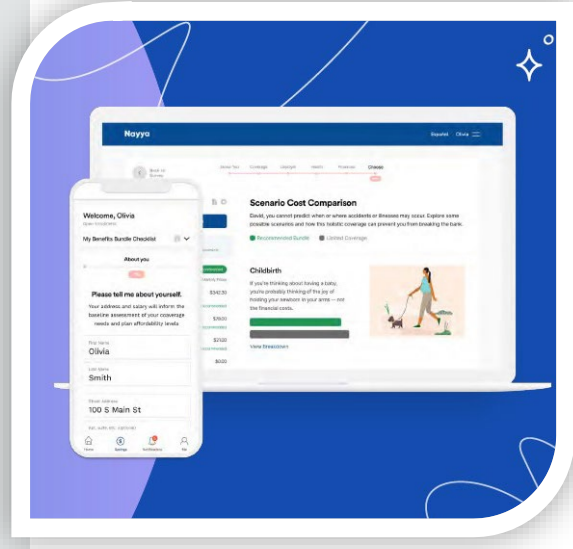
WE'LL TAKE CARE OF THE HEAVY LIFTING
Nayya provides a bundled recommendation that encompasses the full portfolio of your available benefits, including medical, dental, and vision, as well as HSA investment support, providing a holistic view of your coverage.

LET'S GET STARTED

1. Your benefits assessment experience kicks off with a welcome email from Nayya that provides instructions on how to claim your account to access the Choose portal, please use the link you received via email or scan the QR code to your right.

2. Within the Choose assessment, you will be asked to connect to your medical insurance carrier. Once linked, Nayya will analyze your past insurance usage to determine the right level of benefits for you moving forward. You will then be asked to answer simple questions about your family, lifestyle, and any upcoming life changes you have planned, such as if you are getting married or having a baby.

3. After finishing the assessment, you will then be provided with your bundled benefits recommendations and directed to complete the enrollment process through BenXpress.



Any questions? We're here to help!

How do I find an In-Network Medical Provider?
For support, you can access the Nayya Help Center within the Nayya Use platform. In the Help Center, you can search our knowledge base, browse FAQs, and chat with a customer service representative. Still can't find what you're looking for? Send us a note at *customersuccess@nayya.com* for more.

HIPAA Compliant AICPA SOC HIPPA and SOC 2 compliant

HEALTH
MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $20 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

A **HIGH DEDUCTIBLE HEALTH PLAN (HDHP)** is an insurance plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

OUT-OF-NETWORK charges are subject to reasonable and customary limitations, which means you are responsible for any charges that exceed the carrier's contracted amount (often referred to as balance billing). Call your insurance carrier or refer to your provider's network directory to verify if the provider is in network.

Preventative Services | Covered at 100% NO COST SHARE

All routine preventive services are covered at 100%, no coinsurance, no deductible as long as the claim is submitted as "routine or preventive" and the services performed falls within the approves list of preventive services. For a complete and updated listing, please go online to *www.healthcare.gov/coverage/preventive-care-benefits/*.

During your wellness visit, please remind your physician that you are visiting for the purpose of a wellness visit and proactively remind your physician to submit and code your wellness visit as preventive in nature. If your visit is submitted with a diagnosis, the wellness visit will not be paid at 100%, but instead, will be subject to deductible and coinsurance. Below are a few examples of services that can be recognized as preventive:

- Routine Wellness Exams, including well baby & child routine exams
- Cholesterol and lipid level screening
- Pelvic exam, pap test and screening mammograms
- Colorectal cancer screening, colonoscopies, sigmoidoscopies (age limit applies)
- Vaccines & immunizations: Hepatitis A & B, Influenza, Pneumonia, Shingles
- Contraceptives (specific list applies)
- Diabetes screenings

Did you know?

You'll pay less out of pocket if you receive care from an In-Network provider.

How do I find an In-Network Medical Provider?

In-Network providers can be found on your provider's website medmutual.com or by downloading the mobile app. Click on the box at the top of the screen "Find a Provider", choose circle "Group", then choose "Medical."

- Advantage Plan, Maximum Value Plan or Minimum Value Plan Providers – choose SuperMed…
- MedFlex Providers– choose MedFlex

HEALTH
MEDICAL PLANS

Medical Coverage is provided through Medical Mutual of Ohio. The County will continue to offer 4 health plan options for 2023. The Advantage Plan, Maximum Value Plan and Minimum Value Plan utilize the SuperMed PPO Provider network. The MedFlex Plan utilizes the MedFlex network. All health plans are effective on January 1, 2023.

MEDFLEX PLAN

The **MedFlex Plan** will be offered in 2023 with enhancements. The Deductible will **DECREASE** to $500 Single/$1,000 Family. All other medical and prescription benefits will remain the same under this benefit plan. This plan will continue to offer in-network only benefits so refer to the Medical Mutual website to verify your providers are in the "MedFlex" network. Refer to page 7 for instructions. The only out-of-network coverage would be in the case of a true life threatening or loss of limb emergency, where you're encouraged you to go the nearest Emergency Room. When traveling out of the network area, you may utilize First Stop Health for your non-emergent needs. Employee premium will **DECREASE** in 2023 for the MedFlex Plan. MedFlex will be the **DEFAULT PLAN** for those who do not enroll through the BenXpress online platform. Virgin Pulse wellness dollars will continue to be placed on an HRA card through TASC.

MAXIMUM VALUE PLAN

The **Maximum Value Plan** is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) option. The Maximum Value Plan offers you the option to choose any provider within the SuperMed PPO network when you need care. In exchange for a lower per paycheck premium, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs. Once your deductible has been satisfied, this plan will then pay at 100% for all medical and prescription drug claims for the remainder of the plan year. Preventive services are covered at 100% and are NOT subject to your deductible. Employee premium will not change in 2023 for the Maximum Value Plan. This plan offers an HSA along with the HDHP. Virgin Pulse wellness dollars will be deposited into your TASC HSA. Employees electing this plan for the first time must initiate enrollment into their HSA Account. Please refer to the *Employee Benefits website* for HSA enrollment instructions.

ADVANTAGE PLAN

The **Advantage Plan** will continue to be offered in 2023 with some changes. The Deductible will increase to $1,000 single/$2,000 family. Once the deductible has been satisfied the plan will pay 80% and the employee will pay 20% up to $2,000 single/$4,000 family. All other benefits including prescription drug will remain the same. Rates for this plan have increased so refer to the rate pages within your Open Enrollment Packet of information located on the *Employee Benefits website*. Virgin Pulse wellness dollars will continue to be placed on an HRA card through TASC.

MINIMUM VALUE PLAN

The **Minimum Value Plan** is remaining the same for 2023. This plan is also an HDHP, but the County does not offer the HSA in conjunction with this plan. This is the only plan offered by the County in which you are not eligible to earn rewards in the Virgin Pulse program.

The Advantage Plan, Maximum Value Plan and Minimum Value Plan provide two levels of coverage, In-Network and Non-Network. Each time you and/or your family member receives care from an in-network provider, there is a higher level of coverage. If the provider is non-network, there is a lower level of coverage that typically results in higher out of pocket costs for you. Non-Network providers may balance bill you for any cost over what Medical Mutual will allow on that service. To ensure your provider is in-network, contact Medical Mutual's customer service line (800) 228-6472 or visit Medical Mutual online at *medmutual.com*.

MEDICAL MUTUAL OF OHIO®

For those in the Advantage Plan, Maximum Value Plan or Minimum Value Plan and you are traveling out of state, you may utilize the Cigna PPO network for benefits to be paid at the in network level.

MEDICAL
HEALTH | PLAN COMPARISON

	MEDFLEX PLAN*	MAXIMUM VALUE PLAN* (HSA)		ADVANTAGE PLAN*		MINIMUM VALUE PLAN	
	In-Network ONLY	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible							
Single	$500	$3,000	$5,200	$1,000	$2,000	$4,000	$8,000
Family	$1,000	$6,000	$10,400	$2,000	$4,000	$8,000	$16,000
Coinsurance (after deductible)	10%/90%	N/A	40%/60%	20%/80%	40%/60%	30%/70%	50%/50%
Single	$2,000	$0	$11,000	$2,000	$4,000	$2,350	$4,700
Family	$4,000	$0	$22,000	$4,000	$8,000	$4,700	$9,400
Maximum Out of Pocket (Includes deductible, coinsurance and all copays)							
Single	$7,350	$3,000	$16,200	$7,350	$22,040	$6,350	$12,700
Family	$14,700	$6,000	$32,400	$14,700	$44,100	$12,700	$25,400
Office Visit - PCP/ Specialist	$20/$40	0% after deductible	40% after deductible	$20/$40	40% after deductible	30% after deductible	50% after deductible
Preventive Office Visit	0%	0%	40% after deductible	0%	40% after deductible	0%	50% after deductible
Emergency Room (waived if admitted)	$150	0% after deductible	0% after deductible	$150	$150	30% after deductible	50% after deductible
Urgent Care - PCP/ Specialist	$40	0% after deductible	40% after deductible	$40	40% after deductible	30% after deductible	50% after deductible
Diagnostic Services (Xray and diagnostic medical tests)	20% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Diagnostic Lab (Free standing facilities)	$20	0% after deductible	40% after deductible	$20	40% after deductible	30% after deductible	50% after deductible
Diagnostic Lab (Institutional)	20% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
		HSA Included				HSA Compatible Plan	
Prescription Drugs							
Retail Pharmacy	$10/$25/$50 (Brand Copay + difference of cost if generic available)			0% after deductible		30% after deductible	
Mail Order/ Smart 90	$20/$50/$100 (Brand Copay + difference of cost if generic available)			0% after deductible		30% after deductible	

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you, your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

PRESCRIPTION DRUGS
RX | PLAN COMPARISON

TRADITIONAL DRUG LIST

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred/formulary brand name drugs. These drugs are more expensive than generics and have a higher copay.

TIER 3 | Highest copay: In this category are the non-preferred/non-formulary brand name drugs for which there is either a generic alternative or a more cost-effective preferred/formulary brand. These drugs have the highest copay. **Make sure to check for mail order and Smart 90 discounts that may be available.**

TO FIND A DRUG LIST:

Visit the Express Scripts website at *express-scripts.com*

Rx Copays	MedFlex	Advantage	Maximum Value Plan with HSA	Minimum Value Plan
TIER 1	$10	$10	Deductible then 100%	Deductible then 100%
TIER 2	$25	$25	Deductible then 100%	Deductible then 100%
TIER 3	$50	$50	Deductible then 100%	Deductible then 100%
Mail Order/ Smart 90	2 times copay	2 times copay	Deductible then 100%	Deductible then 100%

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.

ImpaxRX

This is a Prescription Advocacy Program that assists employees and their dependents with their out-of-pocket costs on specialty 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.

What is Coverage Review or Prior Authorization?

Your plan uses coverage management programs to help ensure you receive the prescription drugs you need at a reasonable cost. Coverage management programs include

- Prior Authorization
- Step Therapy
- Quantity Duration

Each program determines whether your use of certain medications meets your plan's conditions of coverage. In some cases, a coverage review may be necessary to determine whether a prescription can be covered under your plan.

Save Money With Generic (Tier 1) Drugs

Employees on the Advantage and MedFlex Plan will be subject to additional prescription costs if they purchase a brand name drug when a generic drug is available. Employees will pay the brand copay ($25 or $50) plus the difference in cost between the generic drug and brand name drug if a generic is available.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER/ SMART 90 PROGRAM - Many drugs are available in a 90 day supply, rather than the 30 day retail supply. Typically, you will pay less if you choose to get a mail order 90 day supply.

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times there are generic or different manufacturers that will save you money at the pharmacy.

FLEXIBLE SPENDING ACCOUNT
FSA | TAX SAVING VEHICLE

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year **(January 1st through December 31st)**. The only time you can change your election is during the enrollment period or if you experience a Qualifying Life event. Also, you must elect this benefit within **30 days** of first date of benefits eligibility or Qualifying Life Event date.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov**.
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.**fsastore.com**.

HEALTHCARE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,050

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – may be reimbursed from your FSA account.

With the Health Care FSA, you may spend up to the full amount of your annual election as soon as your account has been set up. **If you newly elect the Maximum Value Plan, you forfeit any dollars remaining in your 2022 FSA.**

DEPENDENT CARE FSA

MAXIMUM ANNUAL CONTRIBUTION | $5,000

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school full-time.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$5,000** annually in pre-tax dollars, or **$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

HEALTH CARE FSA GRACE PERIOD

You have until March 15, 2024 to incur claims for reimbursement. You have until March 31, 2024 to submit those claims to TASC for reimbursement. Any 2023 funds in the account after March 31, 2024 are forfeited. To submit for reimbursement of 2022 claims in 2023 you will need to submit a paper claim to TASC.

**ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:*

1. **'Care'** for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. **'Care'** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **'Care'** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

Please note: FSA is a voluntary program and there is no fee to participate. IRS regulations require FSA participants to retain receipts for ALL purchases made through an FSA plan.

HRA | HSA
EMPLOYEE BENEFIT PLANS

HRA

A Health Reimbursement Account (HRA) is a County of Summit funded account you may use to pay for qualified out-of-pocket medical expenses for those on the Advantage and MedFlex Plans. The County makes contributions to the account based on the employee's wellness activities. Your HRA may be used for your expenses as well as those of your enrolled spouse and dependents.

Since the HRA contributions are made by the County and placed in an account for your benefit, you will forfeit any HRA funds left in the account if you terminate employment with the County. **If you newly elect the Maximum Value Plan, you forfeit any dollars (including past roll over dollars) in your 2022 HRA.** TASC will continue to be our HRA provider.

HSA

The County's Maximum Value Plan also offers a Health Savings Account (HSA). An HSA is a personal savings account you may use to pay for qualified out-of- pocket medical expenses with pretax dollars. Both you (through pre-tax funds from your paycheck) and the county (through Virgin Pulse wellness dollars and employer contributions) are able to make contributions to your account, but you own and control the account. Contributions are not taxed, and you may invest the balance in a variety of options. Your account (including interest and investment earnings) grows tax-free and as long as the funds are used to pay for qualified medical expenses, they are spent tax-free. You may use the money in your HSA to pay for qualified medical expenses now or in the future. Your HSA may be used for your expenses and those of your spouse and dependents. The IRS has increased the 2023 employee contribution limits an employee can deposit into their HSA to $3,850 for single coverage and $7,750 for family coverage. These totals also include the Employer Contribution amounts and what you earn through Virgin Pulse so please consider those amounts when determining your employee contribution to ensure you do not over contribute.

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

HSA Eligibility Requirements

To have an HSA and make contributions to the account, you must meet several basic qualifications.

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage);
- ✓ HSA participants cannot participate in a Healthcare FSA or spouse Healthcare FSA or Health Reimbursement Account (HRA).
- ✓ Participants cannot be enrolled in Medicare or Medicaid *(including dependents).*
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days.

The County of Summit will increase their employer contribution to $1,000 single/$2,000 family to offset the deductible increase imposed by the IRS. The amount will be divided in 4 equal parts and deposited quarterly. Please note, you MUST have an open account with TASC and be actively employed at the time of deposit to receive each employer contribution.

ELIGIBLE HSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Automobile modifications for a physically handicapped person
- Birth control pills
- Blood pressure monitoring device
- Braille books & magazines
- Chiropractic care
- Christian science practitioner
- COBRA premiums
- Contact lenses & related materials
- Crutches
- Dental treatment
- Dentures
- Diagnostic services
- Drug addiction treatment
- Eye examination
- Eye glasses & related materials
- Fertility treatment
- Flu shot
- Guide dog or other animal aide
- Hearing aids
- Hospital services
- Immunization
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care premiums or expenses
- Medical testing device
- Nursing services
- Obstetrical expenses
- Organ transplant
- Orthodontia (not for cosmetic reasons)
- Oxygen
- Physical exam
- Physical therapy
- Prescription drugs
- Psychiatric care
- Retiree medical insurance premiums
- Smoking cessation program
- Surgery
- Transportation for medical care
- Weight loss program
- Wheelchairs and more*.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

MAINTAIN RECORDS

To protect yourself in the event that you are audited by the IRS, keep records of all HSA documentation and itemized receipts for at least as long as your income tax return is considered open (subject to an audit), or as long as you maintain the account, whichever is longer.

HSA funds may be used for non-eligible expenses, however they will be subject to regular income taxes and a 20% excise tax penalty.

TELEMEDICINE

24/7 | First Stop Health

NO CROWDED WAITING ROOMS. NO DRIVING. SEE A DOCTOR WHEN YOU NEED A DOCTOR. TALK TO A DOCTOR 24/7.

A virtual visit lets you see and talk to a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions.

DOWNLOAD THE APPS

To make life easier, download the First Stop Health mobile app.

GET IT ON Google Play

Download on the App Store

When can I use *First Stop Health*?

When you have a non-emergency condition and:

- Your doctor is not available;
- You become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

Examples of Non-Emergency Conditions:

- ✓ Bladder infection
- ✓ Bronchitis
- ✓ Diarrhea
- ✓ Fever
- ✓ Pink eye
- ✓ Rash
- ✓ Seasonal flu
- ✓ Sinus
- ✓ Sore throat
- ✓ Stomach

How does it work?

Call (888) 691-7867 or go to *fshealth.com* or download the First Stop Health mobile app to request your doctor visit. We recommend setting up your account now so that's it's ready for you when you need it. You will need to complete the patient registration process to gather medical history, pharmacy preference, primary care physician contact information, and insurance information.

Each time you have a virtual visit, you will be asked some brief medical questions, including questions about your current medical concern. If appropriate, you will then be connected using secure live audio and video technology to a doctor licensed to deliver care in the state you are in at the time of your visit. You and the doctor will discuss your medical issue, and, if appropriate, the doctor may write a prescription for you.

First Stop Health doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. Costs for the virtual visit and prescription drugs are based on, and payable under, your medical and pharmacy benefit.

For questions regarding *First Stop Health*, contact:
1 (888) 691-7867 or ***fshealth.com***

DENTAL
COVERAGE

DENTAL

You have the freedom to select the dentist of your choice; however when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

COMMON TERMS

PRE-TREATMENT ESTIMATE

If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE

You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS

Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

	PRO PLAN	VALUE PLAN
DEDUCTABLE		
Network Details	PPO Dentists **Guardian** Network	PPO Dentists **Guardian** Network
Benefit Period	Calendar Year	
COVERED SERVICES		
Single	**$50**	
Family	**3 per family for a maximum of $150**	
When does it apply?	**When receiving Basic or Major Care Services (Preventive Services do not apply)**	**When receiving Major Care (Preventive services do not apply)**
ANNUAL MAXIMUM		
CLASS I: Preventive Services *Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments*	**Covered at 100%**	**Covered at 100%**
CLASS II: Basic Services *Periodontics (surgical & non-surgical), endodontics (root canals), perio surgery, fillings, prosthetic maintenance & x-rays (full mouth)*	**Covered at 80%**	**Covered at 100%**
CLASS III: Major Services *crowns, inlays/onlays, dentures, implants & bridges*	**Covered at 50%**	**Covered at 60%**
COVERED SERVICES		
Maximum Benefit *Allowed per Benefit Period*	**$1,500 per covered individual**	

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

Balance billing may occur if you seek services from an Out-of-Network provider.

How do I find an In-Network Provider?

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on *guardiananytime.com* choosing the PPO network.

VISION
COVERAGE

EYE CARE

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

	IN-NETWORK DAVIS PROVIDER	OUT-OF-NETWORK REIMBURSEMENT
PLAN FEATURES		
Vision Exam	**$15** copay	Up to **$15**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$15** copay	**$10**
Bifocals	**$15** copay	**$20**
Trifocals	**$15** copay	**$30**
Frames	**Covered in full** for Davis Vision's collection; **$15** Copay for designer frames; **$40** copay or **$100** retail allowance for Premier Frames	Up to **$30**
COVERED SERVICES		
Contact Lenses	**Covered in full** for Davis Vision Contact Lens Collection or **$100** Retail allowance	Medically necessary Up to **$75;** Elective Contracts up to **$40**
Contact Lens Evaluation Fitting	**15% Discount Only**	Not Applicable
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 12 Months	Once every 12 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam may help detect signs of other serious health conditions such as diabetes and high cholesterol. It is important to receive annual exams as symptoms to these conditions can go unnoticed and may cause early and irreversible damage.

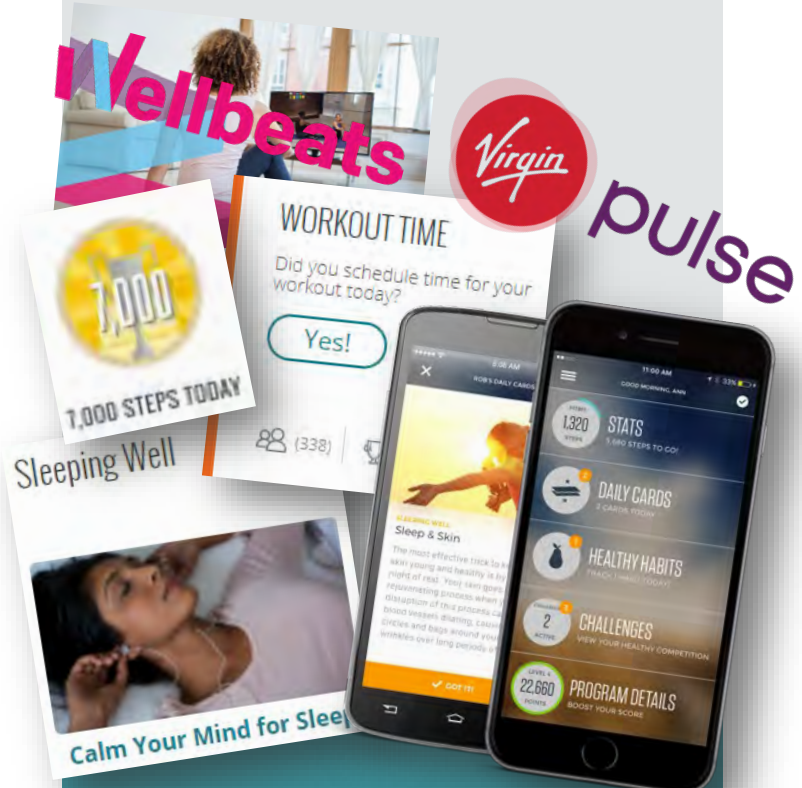
Need to locate a participating In-Network provider?

Go to *davisvision.com*

WELLNESS
VIRGIN PULSE | WELLNESSIQ

MAKE BEING HEALTHY FUN AND REWARDING

Let's build small habits each day that add up to big changes…Virgin Pulse



WELLNESS AT YOUR FINGERTIPS

Go to the Employee Benefits Website for more on *Virgin Pulse* or download the app on your device through the app store to get started.

GET IT ON Google Play

Download on the App Store

COUNTY OF SUMMIT HEALTH & WELLNESS

Well-being is the main focus for our employees, their dependents and/or spouses. The Wellness Team's Core Values are to encourage, involve and increase health and wellness participation amongst employees. This will allow the employees to focus on a sound body, mind and spirit.

The mission of our Wellness Team is to promote a health-giving environment for all County of Summit Employees, including mental well-being, physical, financial, and nutritional health. We offer health and wellness programs, County fitness facilities, and multiple discounts, amongst other things, which are at little to no cost to the employee.

The vision of the Wellness Team is to create a healthy environment for all County of Summit Employees. The goal is to offer health and wellness programs valuable to all employees without it being a financial burden to the employee or the County.

The County's Wellness platform, Virgin Pulse, will continue to be offered to those employees enrolled in the MedFlex Plan, Advantage Plan, and the Maximum Value Plan. The Minimum Value Plan does not allow employees to earn Virgin Pulse Points or Rewards.

The Virgin Pulse Plan year starts January 1st and runs through mid-December each year. This yearly plan gives participant's the opportunity to earn points each quarter by participating and completing wellness activities which equates to dollars. **These dollars earned may be used to pay for qualified healthcare expenses.** A full list of qualified expenses can be found in IRS Publication 502 at *www.irs.gov*.

If you are not already registered, you may register anytime at *join.virginpulse.com/summit*. Instructions on how to register are available on the Employee Benefits website under the "Wellness Platform" page.

BASIC LIFE/AD&D
Guardian COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A **Beneficiary** is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

BASIC LIFE INSURANCE

Your Basic Life coverage includes Accidental Death and Dismemberment coverage. Coverage provided by the county if you meet eligibility requirements.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

MANAGE YOUR BENEFITS

Go to *GuardianAnytime.com* to access secure information about your Guardian benefits. Your online account will be set up within 30-days after your plan effective date.

VOLUNTARY LIFE | AD&D RATES
GUARDIAN COVERAGE OPTIONS FOR YOU & THE FAMILY

VOLUNTARY LIFE INSURANCE

Employees have the opportunity to enroll in Supplemental Life Insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage.

PLAN OPTIONS		
Employee Benefit	$10,000 increments to a maximum of $300,000. Annual Election option allows employee and spouse to enroll or increase their life coverage without a medical exam, up to two increments (employee: up to $20,000; spouse up to $10,000) Amounts above the two increments are subject to evidence of insurability.	
Accidental Death & Dismemberment	Enhanced employee coverage. $10,000 increments to a maximum of $300,000.	
Guarantee Issue	The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during your *initial* enrollment period.	
Premiums	Increase on your plan anniversary after you enter the next five-year age group.	
PLAN PROVISIONS		
Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)	
Benefit Reduction Schedule	**Employee Coverage Will Reduce To:** – 35% of the original amount at age 70 – 55% of the original amount at age 75	**Spouse Coverage Will Reduce By:** The same amount and at the same time your coverage reduces
Portability	Allows you to take your coverage with you if you terminate employment. (Age and other restrictions apply.) You only have 31-days after your group life insurance end to contact Guardian to port policy.	
Conversion	Allows you to continue your coverage after your group plan has terminated. (Restrictions apply.) You only have 31-days after your group life insurance end to contact Guardian to convert policy.	
Accelerated Life Benefit	A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	
Waiver of Premium	Premium will not need to be paid if you are totally disabled, as defined by the plan. For employees disabled prior to age 60, with premiums waive until age 65, if conditions are met.	

*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

VOLUNTARY LIFE | AD&D RATES
GUARDIAN

VOLUNTARY LIFE

AGE	MONTHLY RATE PER $10,000	MONTHLY SMOKER RATE PER $10,000
<25	0.65	**1.24**
25-29	0.65	**1.24**
30-34	0.80	**1.31**
35-39	1.02	**1.74**
40-44	1.67	**2.91**
45-49	2.41	**5.31**
50-54	4.07	**8.59**
55-59	6.98	**15.56**
60-64	10.97	**19.04**
65-69	17.34	**30.60**
70-74	27.71	**48.62**
75-79	27.71	**48.62**
80-84	27.71	**48.62**
85-89	27.71	**48.62**
90-99	27.71	**48.62**

HOW TO CALCULATE OPTIONAL LIFE PREMIUM

Life rates are based on age and per $10,000 of benefit coverage. Find your rate from the proposal and note the rate, then complete the information below to find your monthly premium.

Monthly Rate per $10,000 of coverage:

_____ (A) Maximum of $300,000 $ _____ (B) of coverage x _____ (A-Rate) / 10,000 = _____ (C) Monthly Premium.

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.	
Dependent Children Benefit:	$5,000
Monthly Rate:	$1.00
Premium covers all dependent children regardless of the number of children.	

ACCIDENTAL DEATH & DISMEMBERMENT

	MONTHLY RATE PER $10,000	BENEFITS IN $10,000	MONTHLY COST
Employee	0.48		
Family (Employee + Spouse + Child)	0.76		
Example Employee	0.48	150	$7.20

Employee Monthly Premium for Accidental Death and Dismemberment Coverage
Refer to Program Specifications for your maximum benefit amounts.
EXAMPLE: Use your elected benefit amount in this formula to estimate your premium.

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.*

EASE@WORK
EMPLOYEE ASSISTANCE PLAN

24/7
365

TOTAL WELL-BEING
NOW IN THE PALM OF YOUR HAND

A TOTAL WELL-BEING EAP	COUNSELING	WE HELP WITH:
Ease@Work provides Total Well-Being solutions for organizations and employees by combining high touch services through high tech delivery capabilities. Our Total Well-Being services are available anywhere at anytime to address any problem.	When overwhelmed with personal, work or life stressors, mental health counseling can be a lifesaver. Our licensed, master's level counselors support you and your family through difficult times providing confidential assistance 24/7. Access EAP counseling via phone, web portal, mobile app, chat, and video.	• Family Conflict • Couples/Relationships • Substance Abuse • Work/Life Balance • Depression • Anxiety • Parenting • Stress

EASE@WORK
An AllOne Health Company

Need to contact EASE@Work?
Call them at 1 (800) 521-3273

Prior to going to their website, visit the Employee Benefits Website under EAP for detailed information then go to *www.easeatwork.com*

EASE@WORK
EMPLOYEE ASSISTANCE PLAN

WORKLIFEMATTERS

WorkLifeMatters provides guidance for personal issues that you might be facing and information about their concerns that affect your life, whether it's a life event or on a day-to-day basis.

Unlimited free telephonic consultation with an EAP counselor available 24/7 at 1 (800) 386-7055. Referral to local counselors – up to three sessions free of charge.

State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center.

EASE@WORK CAN OFFER SUPPORT WITH:

EDUCATION

- Admissions testing & procedures
- Adult re-entry programs
- College planning
- Financial aid resources
- Finding a pre-school

DEPENDANT CARE & CARE GIVING

- Adoption Assistance
- Before/after school programs
- Day care
- Elder care
- In-home services
- Parenting classes/support
- Respite care
- Senior housing options
- Special needs care

LEGAL & FINANCIAL

- Basic tax planning
- Credit & collections
- Debt counseling
- Home buying
- Immigration
- Legal Forms
- Personal/family legal
- Retirement planning
- Will making

LIFESTYLE & FITNESS MANAGEMENT

- Anxiety & depression
- Divorce & separation
- Drugs & alcohol
- Grief & loss
- Health & well-being
- Nutrition & fitness
- Pet care
- Relationship issues
- Stress

WORKING SMARTER

- Balancing work and home life
- Career development
- Effective managing
- Relocation
- Stress
- Training development
- Workplace diversity
- Workplace productivity

VOLUNTARY BENEFITS - AFLAC
ACCIDENT

ACCIDENTAL INSURANCE

A sudden accident might stop you in your tracks, but your bills — mortgages, utilities, groceries and out-of-pocket costs — will keep on coming. Aflac Group Accident insurance can help cover the costs associated with the treatment of a covered accidental injury. More importantly, the plan helps you focus on getting better, not worrying about how you'll pay your bills. Because Aflac pays cash benefits directly to YOU. AFLAC's Group Accident plan gives you the flexibility to use your benefits any way you see fit either on costs related to treatment or to help with everyday living expenses.

Who Gets Paid?

You get paid. When you have a covered accident or injury, your health insurance company pays your doctor or hospital, but your accident insurance company pays you.

What's Covered?

Not all accidents are "qualifying injuries." The kinds of accidents that are covered can vary by plan but accident insurance plans typically cover things like:

IF YOU HAVE A COVERED INJURY, ACCIDENTAL INSURANCE CAN HELP YOU PAY FOR THINGS LIKE:

- Emergency Room Visits
- Ambulance Transportation
- Emergency Helicopter Transportation
- Hospital Admissions & Per Diem Charges
- Intensive Care &Rehabilitation Unit Care
- Diagnostic Exams
- Follow-up Treatments
- Physical Therapy
- Emergency Dental Work
- Prescriptions

SUMMIT COUNTY (PER PAY RATES)	
COVERAGE	RATES
Employee	$9.04
Employee & Dependent Spouse	$14.92
Employee & Dependent Child(ren)	$18.24
Family	$24.12

Additional Rider Benefit

Wellness Rider: $50: payable twice per calendar year for employee and spouse and once per calendar year per child.

Accidental Death Rider: Payable if a covered accidental injury causes the insured to die.

Organized Athletic Activity Rider: 20% - coverage for accidental injuries sustained while participating in an organized athletic event.

What it Doesn't Cover?

Accident insurance will not typically cover things like check-ups or hospitalization due to illness. Accident insurance will not cover you for injuries suffered before you purchased the plan.

WELLNESS BENEFIT included with Accidental per covered individual

For wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

VOLUNTARY BENEFITS - AFLAC
CRITICAL ILLNESS

CRITICAL ILLNESS INSURANCE

The Aflac Group Critical Illness Plan provides cash benefits when an insured person is diagnosed with a covered critical illness-and these benefits are paid directly to you (unless otherwise assigned). The plan provides a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness. It is also H.S.A.-compatible. This benefit is payroll deducted.

What is the cost of Critical Illness Insurance?

Coverage is available for you, spouse, and children. Each dependent child is covered at 50% of the primary insured benefit amount at no additional charge.

PREMIUM RATES
EMPLOYEE UNI-TOBACCO MONTHLY PREMIUM

AGE	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-25	$4.43	$5.85	$7.26	$8.68	$10.09	$11.51
26-30	$5.07	$7.12	$9.17	$11.22	$13.26	$15.31
31-35	$5.55	$8.08	$10.62	$13.15	$15.68	$18.21
36-40	$6.53	$10.04	$13.56	$17.07	$20.58	$24.09
41-45	$7.37	$11.73	$16.08	$20.43	$24.79	$29.14
46-50	$8.33	$13.64	$18.95	$24.26	$29.57	$34.88
51-55	$11.60	$20.18	$28.76	$37.33	$45.91	$54.49
56-60	$11.48	$19.93	$28.39	$36.84	$45.30	$53.76
61-65	$20.87	$38.71	$56.56	$74.40	$92.25	$110.09
65+	$34.76	$66.50	$98.24	$129.97	$161.71	$193.45

PREMIUM RATES
SPOUSE UNI-TOBACCO MONTHLY PREMIUM

AGE	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-25	$4.43	$5.85	$7.26	$8.68	$10.09	$11.51
26-30	$5.07	$7.12	$9.17	$11.22	$13.26	$15.31
31-35	$5.55	$8.08	$10.62	$13.15	$15.68	$18.21
36-40	$6.53	$10.04	$13.56	$17.07	$20.58	$24.09
41-45	$7.37	$11.73	$16.08	$20.43	$24.79	$29.14
46-50	$8.33	$13.64	$18.95	$24.26	$29.57	$34.88
51-55	$11.60	$20.18	$28.76	$37.33	$45.91	$54.49
56-60	$11.48	$19.93	$28.39	$36.84	$45.30	$53.76
61-65	$20.87	$38.71	$56.56	$74.40	$92.25	$110.09
65+	$34.76	$66.50	$98.24	$129.97	$161.71	$193.45

PLAN BENEFITS
Benefit provision may vary by situs state

BASIC BENEFITS	
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Major Organ Transplant*	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%

**25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant*

CANCER BENEFITS	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	$250 per calendar year

HEALTH SCREENING BENFIT
Health Screening Payable for Employee and Spouse Only

OPTIONAL BENEFITS RIDER	
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%
Benign Brain Tumor	100%

Please request a sample policy for full benefit provisions and descriptions.

Portability

If you leave employment for any reason, worksite benefits can be converted to a direct-pay policy. The same benefits and premium rate will apply. AFLAC will send a notice to your home address following your termination from the group plan.

WELLNESS BENEFIT included with Critical Illness per covered employee and spouse only. Dependent children not covered.
Once per calendar year for health screening tests performed as a result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

VOLUNTARY BENEFITS - AFLAC
HOSPITAL INDEMNITY

HOSPITAL INDEMNITY INSURANCE

It provides financial assistance to enhance your current coverage. It may help avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child-care, or time away from work, for instance.

What's Covered?

- **HOSPITAL ADMISSION BENEFIT** per confinement : **$2,000** (once per covered sickness or accident per calendar year for each insured)
- **HOSPITAL CONFINEMENT** per day: **$200** (maximum of 31 days per confinement for each covered sickness or accident for each insured)
- **HOSPITAL INTENSIVE CARE BENEFIT** per day: **$200** (maximum of 10 days per confinement for each covered sickness or accident for each insured.
- **INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT** per day**: $100** (maximum of 10 days per confinement for each covered sickness or accident for each insured. (This benefit is payable in addition to the Hospital Confinement Benefit)

PER PAY PREMIUMS	
COVERAGE	PREMIUM
Employee	$15.83
Employee & Dependent Spouse	$32.06
Employee & Dependent Child(ren)	$25.06
Family	$41.29

VOLUNTARY BENEFITS - TRUSTMARK
UNIVERSAL LIFE WITH LONG-TERM CARE

TRUSTMARK UNIVERSAL LIFEEVENTS® INSURANCE WITH LONG-TERM CARE BENEFITS

Financial security even after a loss Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. Universal LifeEvents can help. Universal LifeEvents provides a higher death benefit during your working years, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a plan and benefit amount that provides the right protection for you. Universal LifeEvents insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the ending of one story won't stop the beginning of another.

UNIVERSAL LIFEEVENTS SAMPLE RATES

Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.

AGE AT PURCHASE	$25,000 Universal LifeEvents Policy
30	From $3.49 to $4.59
40	From $5.05 to $6.71
50	From $7.84 to $10.71
Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.	

NOTE: your rate is "locked in" at your age at purchase!
Once you have a policy, your rate will never increase due to age.

HOW UNIVERSAL LIFEEVENTS WORKS

- A **higher death benefit** during working years.
- **Long-term care (LTC)** benefits that **stay the same** throughout your life.

Example: $25,000 policy

Before age 70	
Death Benefit	$25,000
LTC Benefits	$25,000
After age 70	
Death Benefit	$8,333
LTC Benefits	$25,000
Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary.	

SOLVING THE LONG-TERM CARE ISSUE

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC)** benefit that can help pay for those services at any age. This benefit **remains at the same** level throughout your life, so the full amount is always available when you most need it.

Here's how it works:

4% You can **collect 4% of your Universal LifeEvents death benefit per month** for up to 25 months to help pay for long-term care services.

Flexible features available:

5% **PLUS:** if you collect a benefit for LTC, your **full death** benefit is still available for your beneficiaries, as much as **doubling** your benefit.

3% **PLUS:** you can collect your LTC benefit for an **extra 25 months**, as much as **tripling** your benefit.

Additional Advantages

Wellness Rider at the same price and benefits if you change jobs or retire.

Apply for coverage for family members: Payable if a covered accidental injury causes the insured to die.

Convenient payroll deduction: pay via direct bill, bank draft or credit card if you leave your employer.

More Flexible Features

Waive your policy payments if your doctor says you're totally disabled.

VOLUNTARY BENEFITS - TRUSTMARK
PAYCHECK PROTECT | SHORT-TERM DISABILITY

TRUSTMARK PAYCHECK PROTECT® INSURANCE | SHORT-TERM DISABILITY

Paycheck Protect helps to insure your livability and lifestyle, ensuring that nothing gets in the way or keeps you down. With it, you can go about life knowing if something happens and you can't do your regular job, Paycheck Protect will replace part of your paycheck. That cash can be used for whatever helps keep you going.

PAYCHECK PROTECT SAMPLE RATES

Sample ranges of weekly rates for 3-month coverage with a 14-day elimination period for disability due to either injury or illness, for lower-risk occupations.

ISSUE AGE	$1,000 MONTHLY BENEFIT
18-49	From $4.81 to $8.14
50-59	From $5.69 to $9.32
60-70*	From $5.86 to $10.61

**Maximum issue age may vary by state.*

Sample base rates are shown for illustrative purposes only. Rates may vary by age, state, employer, occupational class and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

NOTE: once you have a policy, your rates will not increase due to age!

EXAMPLE OF BENEFITS

$1,000/month policy, 2 ½ months unable to work, following elimination period:

First Month:	$1,000
Second Month:	$1,000
Last 15 Days	$500
Total Benefits Paid:[5]	$2,500

COVERED CONDITIONS

Paycheck Protect insurance kicks in when you can't work due to[1]:

- **Sickness** (off-the-job)
- **Injury** (off-the-job)
- **Mental Wellness** issues
- Treatment for **addiction recovery**
- **Maternity** (6-8 weeks of benefits after delivery)[2]
- **Complications of pregnancy**

Guarantee Issue enrollment with all pre-existing conditions waived (waiver includes maternity) for 2023 only with an effective date of coverage of 01/01/2023.

[1]Benefit payment is subject to terms and conditions of coverage. Preexisting condition limitations may apply.
[2]Maternity benefit duration varies by delivery type.
[5]Benefits paid may vary.

Trustmark®
benefits beyond benefits

Additional Advantages

- Benefits can be paid weekly, providing quick access to your money.
- Premium deductions are waived if you remain unable to work after 90 consecutive days during your benefit period.
- Keep your coverage at the same price and benefits if you change jobs or retire. Coverage ends at age 70, or after 5 years if you purchase at age 66 or older.

IMPORTANT CONTACT INFORMATION
DIRECTORY

PROVIDER CONTACT INFORMATION

Do you need more information about a specific benefit or option? Contact the provider directly to request details about the coverage, provider networks, claim issues, or to order an ID card. For unresolved questions, please contact the employee benefit line at (330) 643-5551 to leave a message.

For eligibility questions / issues, contact Kym Komaschka at kkomaschka@summitoh.net, (330) 643-2621 or Monica Siko at msiko@summitoh.net, (330) 643-8867. For claim issues contact Lisa Yeager at lyeager@summitoh.net, (330) 643-8763.

Please visit the Employee Benefits website at hreb.summitoh.net for additional plan information.

MEDICAL PLAN		
Medical Mutual: Customer Service Contact for claims & benefit questions, prior authorizations	1 (800) 315-3137	*medmutual.com*
First Stop Health: Customer Service	1 (888) 691-7867	
PRESCRIPTION PLAN		
Express Scripts (administered by Medical Mutual): Customer Service	1 (800) 417-1961	*express-scripts.com*
DENTAL PLAN		
Guardian Dental: Customer Service (Plan Number: 00543971)	1 (888) 600-1600	*GuardianAnytime.com*
VISION PLAN		
Davis Vision: Customer Service (Group Number: 503957) (Client Code: 2968)	1 (800) 999-5431	*davisvision.com*
EMPLOYEE ASSISTANCE PROGRAM (EAP)		
EASE@Work: Customer Service (Username: Summit County Password: ease)	1 (800) 521-3272	*easeatwork.com/login*
FLEXIBLE SPENDING ACCOUNTS, HEALTH REIMBURSEMENT ACCOUNTS & HEALTH SAVINGES ACCOUNTS		
TASC: Customer Service Look up covered expenses, learn about plan, register and manage your account online	1 (800) 422-4661	*tasconline.com*
COBRA		
TASC	1 (800) 422-4661	
VIRGIN PULSE		
Virgin Pulse: Customer Service Look up covered expenses, learn about plan, register and manage your account online	1 (888) 671-9395	*join.virginpulse.com/Summit*
VOLUNTARY BENEFITS		
Aflac & Trustmark: Customer Service or Charlie Frankel For questions, claims, service or cancellations	1 (216) 262-3330 1(800) 433-3036	*Charlie.Frankel@NFP.com* *cscmail@aflac.com*

ILENE SHAPIRO
COUNTY EXECUTIVE