County of Summit · The High Point of Ohio

ILENE SHAPIRO
COUNTY EXECUTIVE

COUNTY OF SUMMIT

EMPLOYEE BENEFITS

hreb.summitoh.net

- Medical Plans & Benefit Elections
- Prescription Plans
- Health & Wellness
- Dental Plan and Vision Plan
- HRA/ Health Savings Account
- Flexible Spending Account
- Life Insurance
- Employee Assistance Program
- 457 Deferred Compensation Plans
- Voluntary Benefits

1

Benefit Elections

Elections made as a new hire are made for the calendar year

Waiting period:

- New hires are eligible on their date of hire.
- Must enroll within 30 days of eligibility date (hire date) through BenXpress online enrollment system.

The next time you can make changes:

- Open Enrollment, held in 4th quarter each year
- Qualifying Event – marriage, divorce, birth or adoption of a child, spouse loses employment, or death of a dependent
- Changes must be made within 30 days of the event.

Benefit Elections

Monthly Health Cash Waiver:

- Proof of other coverage is required

- County employees have a cash option that may be exercised if they decline medical and prescription coverage and provide proof that they are covered under another medical plan outside the County's program. Those opting out will receive $50 per month. You will still be eligible for the other employee benefit programs (with the exception of Virgin Pulse, our wellness program).
- County employees that are married or related to each other and elect County coverage under one employee are not eligible for the waiver.

Eligibility

- Full Time Employees working at least 30 hours per week
- Eligibility Verification required for dependents

Eligible Dependents

- Spouse
- Employee or Spouse's:
  - Natural children;
  - Stepchildren;
  - Children placed for adoption and legally adopted children;
  - Children for whom either employee or spouse is the Legal Guardian; or
  - Any children who, by court order, must be provided health care coverage by the employee or spouse.

Children are covered up to age 26 on Medical/Rx, Dental and Vision.

Employee Benefits website

All benefit information is available on the Employee Benefit website

Employee Benefits Website:
https://HREB.summitoh.net

COUNTY OF SUMMIT

MEDICAL & PRESCRIPTION BENEFITS

hreb.summitoh.net

	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	

*Virgin Pulse Wellness Program is available to all employees and spouses enrolled in the Advantage, MedFlex and Maximum ValuePlans. The Minimum Value Plan is not eligible.

Medical Mutual of Ohio/ Express Scripts

Medical and Prescription Drug

MedFlex Plan

- $20 PCP/$40 Specialist Office Visit Copay
- $500 Single/$1,000 Family In-Network Deductible
- Insurance pays 90% after deductible is met for In-Network, you pay 10%
- $2,000 Single/$4,000 Family Coinsurance In-Network
- Preventive services covered at 100%
- No out of network benefits except in the case of true emergency
- Narrow Network - Medical Mutual's MedFlex Network must be used
  - Summa
  - Children's Hospital
  - University Hospitals

Please note that Cleveland Clinic and Cleveland Clinic Akron General are NOT in this network of hospitals or providers.

Please refer to the Medical Mutual website to see a full list of providers and facilities in the MedFlex Network www.MedMutual.com

Medical Mutual of Ohio/ Express Scripts

Medical and Prescription Drug

Advantage Plan

- $20 PCP/$40 Specialist Office Visit Copay
- $1,000 Single/$2,000 Family In-Network Deductible
- Insurance pays 80% after deductible is met for In-Network, you pay 20%
- $2,000 Single/$4,000 Family Coinsurance In-Network
- Preventive services covered at 100%
- Utilizes Medical Mutual's SuperMed PPO Network

Medical Mutual of Ohio/ Express Scripts

Prescription Drug Plan for the Advantage and MedFlex Plans

- Rx Copays – Generic mandated plan
  - $10/$25/$50 +difference – for 31 day Retail
  - $20/$50/$100 +difference– for 90 day Mail Order
    - You pay the cost difference between Brand and Generic, plus the Brand copay, if you choose a Brand Rx when Generic is available.
    - Mandatory Maintenance Program - All maintenance medications must be filled for a 90-day supply through Mail Order or the Smart90 program. You will be able to get two, 30-day fills of NEW maintenance medications filled at an in-network retail pharmacy and then all subsequent refills must be written for a 90-day supply and filled via mail order or at a pharmacy participating in the Smart 90 program.

Medical Mutual of Ohio/ Express Scripts

Medical and Prescription Drug

Minimum Value Plan

- High Deductible Health Plan (HDHP)
- $4,000 Single/$8,000 Family In-Network Deductible
- Insurance pays 70% after deductible is met for In-Network, you pay 30%
- $2,350 Single/$4,700 Family Coinsurance In-Network
- Preventive services covered at 100%
- Prescription Drugs (full cost) are subject to the deductible
- The county does not offer the HSA with this plan but you may open your own
- This is the only plan offered by the county you are unable to earn rewards in the Virgin Pulse Program

Medical Mutual of Ohio/ Express Scripts

Medical and Prescription Drug

Maximum Value Plan

- High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)
- $3,000 Single/$6,000 Family In-Network Deductible
- Once Deductible is met, plan pays 100%
- Preventive services covered at 100%
- Prescription Drugs (full cost) are subject to the deductible
- The county does offer the HSA with this plan
- Virgin Pulse money earned with this program will be deposited into your HSA account through Medical Mutual
- TASC will send everyone information on how to enroll in the HSA plan once open enrollment is completed

TASC

Health Savings Account (HSA)

- Must be used in conjunction with a HDHP
- Personal Savings Account you own
- Used to pay for qualified medical expenses now or in the future
- Make pretax contributions to your account through payroll deduction
- Contributions are not taxed
- Can invest in a variety of options
- Maximum you may deposit is $3,850/$7,750 (+$1,000 catch up age 55 and older)
- FAQ – Please refer to the FAQ on the Employee Benefits website for specific questions and answers regarding the HSA
- Members enroll in TASC once elections have been completed

TASC

Health Savings Account (HSA) - Eligibility

You are HSA eligible if:

- You are enrolled in an HSA-Eligible HDHP
- You are not covered by another non-high deductible health plan, Health Care Flexible Spending Account or Health Reimbursement Account
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare
- You have not received Veteran's Administration Benefits in the past 90 days

TASC

Health Care Flexible Spending Account (HCFSA)

- A way to set aside money on a pre-tax basis to reimburse yourself for eligible out-of-pocket health expenses for you and your dependents*
  - Examples of Eligible Expenses
    - Deductibles
    - Copays
    - Prescription Copays
    - Dental and Vision expenses
- Maximum annual contribution: $3,050
- Use it or lose it
- Money available right away
- Must enroll in this plan every year you wish to participate
- *Can elect HCFSA even if you (or spouse and kids) are <u>not</u> on the County Health Insurance plan.*

TASC

Dependent Care Flexible Spending Account (DCFSA)

- A way to set aside money on a pre-tax basis to reimburse yourself for eligible dependent care expenses
  - Dependent must be a qualified tax dependent
  - Services must be provided in the plan year
  - You must provide name, address, Tax ID of provider for
    - Day Care, After School Care Program, Summer program
- Maximum annual contribution: $5,000
- Use it or lose it
- Money available only after it's been deducted from your pay

Telemedicine Avoids Physician, Urgent Care, and ER Visits

Top 10 Reasons Members Call:

- Sinus Infection / Issue
- Sore Throat / Strep
- Urinary Tract Infection
- Eye Infection / Pink Eye
- Cough
- Rx Refill
- Skin Rash
- Muscular/Joint Pain
- Ear Ache
- Upset Stomach

888-691-7867

Available to County of Summit FULL-TIME employees and their immediate family members

First Stop Health – Tips and Information

- There is no cost to employees for using FSH.
- Regardless of what plan you choose, FSH is available to FULL-TIME employees and their immediate family members, even if not enrolled in County health plan.
- If you have the Maximum Value Plan or the Minimum Value plan, there is still not cost to you to utilize their service therefore nothing is applied to your deductible.
- If you choose the MedFlex plan and you are out of the servicing area, you do not have non-emergency use of an Emergency Room coverage. To seek services for non-emergent issues (ear infections, sore throat, rash), you may contact FSH for medical attention.
- If you require a doctors note for work or school, when you are speaking with the provider, let them know so they can email this to you. This does not automatically happen and must be requested.

COUNTY OF SUMMIT

Virgin Pulse

hreb.summitoh.net

19

A message from Virgin Pulse.

"Virgin Pulse respects your privacy and wants you to have a happy, healthy life! We will not share your individual data with your employer without your additional consent. Please read your privacy policy for more details."

20

Available with Advantage Plan, MedFlex Plan and Maximum Value Plan

Virgin Pulse is a comprehensive, interactive, and personalized wellness program!

Employees have the opportunity to participate in the County's wellness program through the Virgin Pulse platform. By completing wellness activities, employees earn points that will equate to money they can spend on qualified out of pocket medical expenses such as Deductibles, Coinsurance, Office Visit Copays and Prescription Copays, Dental expenses and Vision Expenses.

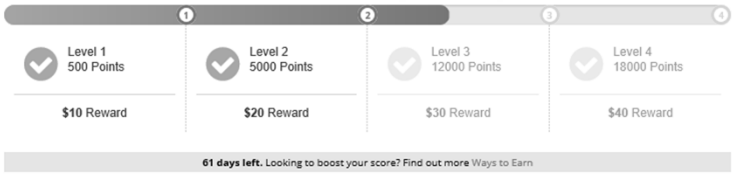
If you are on the Advantage or MedFlex Plans, employees have the ability to roll over unused money from year to year. The maximum roll over amount an employee my roll over is $1,000 for single policy holders and $2,000 for employee and spouse.

If you are on the Maximum Value Plan, money you earn will be deposited into your Health Savings Account, so you must open that account as soon as you are enrolled in the Medical plan.

Reward Levels

(Do health things, earn points, win rewards)

- Accumulate as many points as you can and try to hit level 4 every quarter!
- You have the opportunity to earn $550 each year.
  - $50 for Health Risk Assessment Completion
  - $50 for Biometric Screen
  - $50 for Completing the Nicotine-Free Agreement (Employee Only)
  - $100 per quarter for hitting various levels in Virgin Pulse
- On Dec 31st (program anniversary) your account will reset to zero and the fun starts all over again. (Please note, VP points stop accumulating mid December so please plan accordingly.)



Ways to Earn Points

- Customize the program based on your personal interests
- Cards (2/day at 20 points each)– Tips to make health choices in all areas of your wellbeing
- Healthy Habits (3/day at 10 points each) – Track your progress toward positive behavior changes
- Checklist – Ways to earn checklist shows all of your earning opportunities
- Monthly Statement – Quick snapshot of your points and rewards
- Programs page includes-
  - ✓ Routine Services - Annual Exams, Dental Exam, Vision Exams, Flu Shots. Mammograms, PSA. Pap Tests, Colorectal Screenings
  - ✓ PCP form for biometrics (If you do not participate in the County screenings)
  - ✓ Journey Programs
  - ✓ Nutrition Guide – Zipongo
  - ✓ Sleep Guide
  - ✓ Rethink Program

Ways to Earn Points

- County Sponsored Events
  - ✓ Exercise Classes
  - ✓ Lunch and Learns
  - ✓ Blood Drives
  - ✓ On Site Mammograms
- Challenges – Personal and County wide
- Adding friends
- Tracking your steps – Most fitness devices may be attached to Virgin Pulse to help you earn points every day

For questions or assistance with Virgin Pulse:

- WEB
  member.virginpulse.com
- SUPPORT
  (888) 671-9395 or support@virginpulse.com

You may also contact the Wellness Team at 330.434.1FIT (1348).

COUNTY OF SUMMIT

Dental Benefits

hreb.summitoh.net

25

Two benefit designs to choose: Value Plan and PPO.

Employees should search for their provider before choosing a plan

Go to: www.GuardianAnytime.com

To locate a provider: Click "Find A Dental Provider" under Resources

Select: PPO: DentalGuard Preferred (for PPO or Value Plan)

Type in your search information

Click

Guardian Dental	PPO Plan	VALUE Plan
Deductible		
Single	$50	$50
Family (3 per family)	$150	$150
No Deductible for Preventive		
Annual Maximum	$1,500	$1,500
Preventive	100%	100%
Basic	80%	100%
Major	50%	60%
Child Ortho (Age 19)	50%	50%
Ortho Lifetime Maximum	$1,500	$1,500
Claim Payment Basis	Fixed Fee/90th Percentile of Usual & Customary	Fixed Fee Schedule
*Rollover Rewards - Rollover Rewards may be available if insured submits at least one claim for covered charges during a benefit year and, in that benefit year, receives benefits that are not in excess of these Rollover Reward Threshold amounts		
Rollover Reward Threshold*	$700	$700
Rollover Reward Non-Network Amount	$350	$350
Rollover Reward In-Network Amount	$500	$500
Rollover Reward Account Maximum Limit	$1,250	$1,250

COUNTY OF SUMMIT

Vision Benefits

hreb.summitoh.net

27

DAVISVISION
SEE LIFE

Vision Benefits

	IN-NETWORK BENEFITS	OUT-OF-NETWORK REIMBURSEMENT
Eye Examination	Every January 1, Covered in full after $15 copayment	up to $15
Spectacle Lenses	Every January 1, Covered in full for standard single-vision, lined bifocal, or trifocal lenses after $15 copayment	Single Vision $10 Bifocal $20 Trifocal $30
Frames	Every January 1, Covered in full for any Fashion frame from Davis Vision's Collection (value up to $100), Designer Frames $15 copay, Premier Frames $40 copay OR $100 retail allowance toward any frame from provider, plus 20% off balance OR $150 allowance, plus 20% off balance to go toward any frame from a Visionworks family of store locations	Up to $30
Contact Lenses (in lieu of eyeglasses)	Every January 1, Covered in full for any contact lenses from Davis Vision's Contact Lens Collection OR $100 retail allowance toward provider supplied contact lenses, plus 15% off balance	Elective Contacts up to $40 Medically Necessary up to $75
Contact Lens Evaluation, Fitting & Follow Up Care	Every January 1, Collection Contacts: Covered in full OR Non Collection Standard Contacts: Covered in full OR Non Collection Specialty Contacts: $60 allowance with 15% off balance	Not Applicable

COUNTY OF SUMMIT

Life Insurance Benefits

hreb.summitoh.net

29

Life Insurance Benefits

- Provides Basic Life Insurance
- Voluntary Employee Life available in $10,000 increments
- Voluntary Spouse – 50% of Employee Benefit
- Dependent Child Life available - $5,000 benefit
- Voluntary Accidental Death and Dismemberment Coverage
- One Time Enrollment – New Employees can elect up to maximum Guarantee Issue of $300,000.

COUNTY OF SUMMIT

Employee Assistance Program

hreb.summitoh.net

31

ease@work

Call us! 800-521-3273 (EASE)

Or visit us on the web

www.mylifeexpert.com

Company Access Code:

cosummit

- 6 counseling sessions per issue. Most common issues include:
  - Stress
  - Relationship counseling
  - Depression
  - Grief
  - Substance Abuse
- Other services include:
  - Child Care/School Aged Consultation
  - Elder Care Consultation
  - Legal Resources
  - Financial Resources
  - Wellness Services such as Nutrition Coaching, Fitness Coaching, Stress Reduction Coaching and Smoking Cessation

COUNTY OF SUMMIT

457 Deferred Compensation Plans

hreb.summitoh.net

33

Deferred Compensation Plans

Prepare for Retirement

Ohio Public Employees Deferred Compensation
Chris Waters
(330)328-5982 ~ waterc3@nationwide.com

County Commissioners Association of Ohio (OCERP)
Allisa Ritterbach
(380)222-1635
800-284-0444
Allisa.Ritterbach@empower.com

Equitable Advisors
Phillip Natale or Craig Fishel
330.664.1811
Craig.Fishel@axa-advisors.com
phillip.natale@axa-advisors.com

COUNTY OF SUMMIT

Voluntary Products

hreb.summitoh.net

35

Voluntary Products

Enroll online through BenXpress or contact provider to set up an appointment and/or discuss options.

- **Hospital Indemnity Plan**
- **Critical Illness Plan**
- **Accident Plan**
- **Universal life Policy with and without Long Term Care**
- **Short Term Disability**
- **Pet Insurance**
- **Identity Theft**

For Aflac or Trustmark Benefits:

Charlie Frankel

(216) 262-3330

Charlie.Frankel@NFP.com

COUNTY OF SUMMIT

Important Reminders

hreb.summitoh.net

37

Important Reminders

Employee Benefits Website:
https://HREB.summitoh.net/
(select Insurance Benefits)

330.643.5551

(Leave brief message with your contact information for an Employee Benefits member to call you back.)

Once your information is loaded to the County of Summit Payroll system, you will receive an email from our benefits system, BenXpress, to self-enroll in your benefits.

Proof of dependents (birth certificates, marriage license, court documentation) must be submitted to the Employee Benefits Division within 30 days of your effective date.

Next opportunity to make changes:

Open Enrollment

Qualifying Event – Marriage/Divorce, Birth/Adoption, death of a dependent, loss/gain of benefits

COUNTY OF SUMMIT
EMPLOYEE ELIGIBILITY AND ADULT DEPENDENT COVERAGE

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

Eligible dependents include:

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

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

QUALIFYING EVENTS

Marriage

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

Divorce/Dissolution/Legal Separation

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

Birth/Adoption of a Child

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

Birthday/Dependent Age Limit

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

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

REQUIRED DOCUMENTS (Required for new hires and qualifying events)

Employee/Spouse

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

Child

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

Step-Child

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

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

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

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

CHANGE OF ADDRESS

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

IMPORTANT ENROLLMENT REQUIREMENTS

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

SPECIAL ENROLLMENT RIGHTS

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

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

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

2023 CONTRIBUTION RATES – County of Summit

The charts below summarize County and Employee contribution rates for coverage in 2023.

Medical & Prescription Coverage – Medical Mutual of Ohio & Express Scripts

Advantage Plan

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$35.62	$320.62
Family	$95.94	$863.44

MedFlex Plan

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$13.88	$263.75
Family	$37.38	$710.31

Maximum Value Plan w/HSA

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$13.65	$213.92
Family	$36.77	$576.11

Minimum Value Plan

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$11.55	$180.91
Family	$31.10	$487.21

Dental Coverage

Guardian Dental PPO & Value Plans

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$14.41	n/a
Family	$42.71	n/a

Vision Coverage

Davis Vision

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

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

2023 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	

County of Summit
Medical Mutual of Ohio
Maximum Value Plan
HDHP with HSA

ILENE SHAPIRO
COUNTY EXECUTIVE

SuperMed Plus®

Benefit	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age	Age 26 - Removal upon end of month of 26th birthday	
Pre-Existing Condition Waiting Period	None	
Lifetime Maximum	Unlimited	
Benefit Period Deductible – Single/Family	$3,000/$6,000	$5,200/$10,400
Coinsurance	Plan pays 100%	Plan pays 60% after deductible
Maximum Out-of-Pocket (incudes Deductible and Coinsurance) Single/Family	$3,000/$6,000	$16,200/$32,400
Physician/Office Services		
Office Visit (Illness/Injury)	Plan pays 100% after deductible	Plan pays 60% after deductible
Urgent Care Office Visit	Plan pays 100% after deductible	Plan pays 60% after deductible
Preventive Services		
Preventive Services, in accordance with state and federal law	Plan pays 100%	Plan pays 60% after deductible
Preventive Physical Exam (Ages 21 and over)	Plan pays 100%	Plan pays 60% after deductible
ACA Immunizations	Plan pays 100%	Plan Pays 60% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations (To age 21)	Plan pays 100%	Plan pays 60% after deductible
Preventive Mammogram (One per benefit period)	Plan pays 100%	Plan pays 60% after deductible
Preventive Pap Test (One per benefit period)	Plan pays 100%	Plan pays 60% after deductible
Preventive Lab, X-Ray and Medical Tests	Plan pays 100%	Plan pays 60% after deductible
Preventive Endoscopic Services	Plan pays 100%	Plan pays 60% after deductible
Preventive Eye Exam (one per benefit period)	Plan pays 100% after deductible	Plan pays 60% after deductible
Preventive Eye Refraction (one per 24 months)	Plan pays 100% after deductible	Plan pays 60% after deductible
Outpatient Services		
Surgical Services	Plan pays 100% after deductible	Plan pays 60% after deductible
Diagnostic Services - X-Ray, Medical Tests	Plan pays 100% after deductible	Plan pays 60% after deductible
Diagnostic Lab	Plan pays 100% after deductible	Plan pays 60% after deductible
Diagnostic and Routine Prostate Specific Antigen (PSA)	Plan pays 100% after deductible	Plan pays 60% after deductible
Physical Therapy (25 visits combined with Occupational Therapy then subject to Med Review)	Plan pays 100% after deductible	Plan pays 60% after deductible
Occupational Therapy (25 visits combined with Physical Therapy then subject to Med Review)	Plan pays 100% after deductible	Plan pays 60% after deductible
Chiropractic Therapy (25 visits then subject to Med Review)	Plan pays 100% after deductible	Plan pays 60% after deductible
Speech Therapy (10 visits then subject to Med Review)	Plan pays 100% after deductible	Plan pays 60% after deductible
Cardiac Rehabilitation	Plan pays 100% after deductible	Plan pays 60% after deductible
Emergency use of an Emergency Room	Plan pays 100% after deductible	
Non-Emergency use of an Emergency Room	Plan pays 100% after deductible	Plan pays 60% after deductible

Benefit	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	Plan pays 100% after deductible	Plan pays 60% after deductible
Maternity	Plan pays 100% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility	Plan pays 100% after deductible	Plan pays 60% after deductible
Additional Services		
Injectable Contraceptives and Contraceptive Devices	Plan pays 100% after deductible	Plan pays 60% after deductible
Allergy Testing and Treatments	Plan pays 100% after deductible	Plan pays 60% after deductible
Ambulance	Plan pays 100% after deductible	Plan pays 60% after deductible
Durable Medical Equipment	Plan pays 100% after deductible	Plan pays 60% after deductible
Home Healthcare (40 visits per benefit period)	Plan pays 100% after deductible	Plan pays 60% after deductible
Hospice	Plan pays 100% after deductible	Plan pays 60% after deductible
Organ Transplants ($10,000 maximum for patient transportation)	Plan pays 100% after deductible	Plan pays 60% after deductible
Private Duty Nursing	Plan pays 100% after deductible	Plan pays 60% after deductible
Mental Health and Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid based on corresponding medical benefits**	
Outpatient Mental Health and Substance Abuse		

Note: Deductible and coinsurance expenses incurred for services by a non-network provider will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a network provider will also apply to the non-network deductible and coinsurance out-of pocket limits.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or benefit booklet will contain the complete listing of covered services. The covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

Save on SP:

County of Summit
Medical Mutual of Ohio
MedFlex Plan

ILENE SHAPIRO
COUNTY EXECUTIVE

MedFlex

Benefit	Summa Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age	Age 26 - Removal upon end of month of 26th birthday	
Benefit Period Deductible – Single/Family	$500 / $1,000	Not Covered
Coinsurance	Plan pays 90%; Member pays 10% up to $2000/$4000	Not Covered
Maximum Out-of-Pocket (incudes Deductible, Coinsurance and all Medical and Drug Copays) Single/Family	$7,350 / $14,700	Not Covered
Physician/Office Services		
Office Visit (Illness/Injury)	$20 PCP/$40 Specialist copay	Not Covered
Urgent Care Office Visit	$40 copay	Not Covered
All Immunizations	Plan pays 100%	Not Covered
Preventive Services		
Preventive Services, in accordance with state and federal law	Plan pays 100%	Not Covered
Preventive Physical Exam (Ages 21 and over)	Plan pays 100%	Not Covered
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations (To age 21)	Plan pays 100%	Not Covered
Preventive Mammogram (One per benefit period)	Plan pays 100%	Not Covered
Preventive Pap Test (One per benefit period)	Plan pays 100%	Not Covered
Preventive Lab, X-Ray and Medical Tests	Plan pays 100%	Not Covered
Preventive Endoscopic Services	Plan pays 100%	Not Covered
Preventive Eye Exam (one per benefit period)	$40 copay then Plan pays 100%	Not Covered
Preventive Eye Refraction (one per 24 months)	Plan pays 100%	Not Covered
Outpatient Services		
Surgical Services	Plan pays 90% after deductible	Not Covered
Diagnostic Services - X-Ray, Medical Tests	Plan pays 90% after deductible	Not Covered
Diagnostic Lab	Free Standing Facility - $20 Copay; Institutional - Plan pays 90% after Deductible	Not Covered
Diagnostic and Routine Prostate Specific Antigen (PSA)	Plan pays 100%	Not Covered
Occupational Therapy (25 visits combined with Physical Therapy then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Physical Therapy (25 visits combined with Occupational Therapy then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Chiropractic Therapy (25 visits then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Speech Therapy (10 visits then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Cardiac Rehabilitation	$20 PCP/$40 Specialist	Not Covered
Emergency use of an Emergency Room	$150 copay, then 100% - copay waived if admitted	
Non-Emergency use of an Emergency Room	Not Covered	Not Covered

Benefit	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	Plan pays 90% after deductible	Not Covered
Maternity	Plan pays 90% after deductible	Not Covered
Skilled Nursing Facility	Plan pays 90% after deductible	Not Covered
Additional Services		
Allergy Testing and Treatments	Plan pays 90% after deductible	Not Covered
Ambulance	Plan pays 90% after deductible	Not Covered
Durable Medical Equipment	Plan pays 90% after deductible	Not Covered
Home Healthcare (40 visits per benefit period)	Plan pays 90% after deductible	Not Covered
Hospice	Plan pays 90% after deductible	Not Covered
Organ Transplants ($10,000 maximum for patient transportation)	Plan pays 90% after deductible	Not Covered
Private Duty Nursing	Plan pays 90% after deductible	Not Covered
Mental Health and Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid based on corresponding Medical benefits**	Not Covered
Outpatient Mental Health and Substance Abuse		

Note: Services requiring a copayment are not subject to the single/family deductible or coinsurance.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or benefit booklet will contain the complete listing of covered services. The covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

Save on SP:

ILENE SHAPIRO
COUNTY EXECUTIVE

County of Summit
Medical Mutual of Ohio
PPO – Advantage

SuperMed Plus®

Benefit	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age	Age 26 - Removal upon end of month of 26th birthday	
Benefit Period Deductible – Single/Family	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	Plan pays 80%; Member pays 20% up to $2,000/$4,000	Plan pays 60%; Member pays 40% up to $4,000/$8,000
Maximum Out-of-Pocket (incudes Deductible, Coinsurance and all Medical and Drug Copays) Single/Family	$7,350 / $14,700	$22,050 / $44,100
Physician/Office Services		
Office Visit (Illness/Injury)	$20 PCP/$40 Specialist copay	Plan pays 60% after deductible
Urgent Care Office Visit	$40 copay	Plan pays 60% after deductible
All Immunizations	Plan pays 100%	Plan pays 60% after deductible
Preventive Services		
Preventive Services, in accordance with state and federal law	Plan pays 100%	Plan pays 60% after deductible
Preventive Physical Exam (Ages 21 and over)	Plan pays 100%	Plan pays 60% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations (To age 21)	Plan pays 100%	Plan pays 60% after deductible
Preventive Mammogram (One per benefit period)	Plan pays 100%	Plan pays 60% after deductible
Preventive Pap Test (One per benefit period)	Plan pays 100%	Plan pays 60% after deductible
Preventive PSA (Prostate Specific Antigen)	Plan pays 100%	Plan pays 60% after deductible
Preventive Lab, X-Ray and Medical Tests	Plan pays 100%	Plan pays 60% after deductible
Preventive Endoscopic Services	Plan pays 100%	Plan pays 60% after deductible
Preventive Eye Exam (one per benefit period)	$40 copay then Plan pays 100%	Plan pays 60% after deductible
Preventive Eye Refraction (one per 24 months)	Plan pays 100%	Plan pays 60% after deductible
Outpatient Services		
Surgical Services	Plan pays 80% after deductible	Plan pays 60% after deductible
Diagnostic Services - X-Ray, Medical Tests	Plan pays 80% after deductible	Plan pays 60% after deductible
Diagnostic Lab	Free Standing Facility - $20 Copay; Institutional - Plan pays 80% after Deductible	Plan pays 60% after deductible
Diagnostic and Routine Prostate Specific Antigen (PSA)	Plan pays 100%	Plan pays 60% after deductible
Occupational Therapy (25 visits combined with Physical Therapy then subject to Med Review)	$20 PCP/$40 Specialist	Plan pays 60% after deductible
Physical Therapy (25 visits combined with Occupational Therapy then subject to Med Review)	$20 PCP/$40 Specialist	Plan pays 60% after deductible
Chiropractic Therapy (25 visits then subject to Med Review)	$20 PCP/$40 Specialist	Plan pays 60% after deductible
Speech Therapy (10 visits then subject to Med Review)	$20 PCP/$40 Specialist	Plan pays 60% after deductible
Cardiac Rehabilitation	$20 PCP/$40 Specialist	Plan pays 60% after deductible
Emergency use of an Emergency Room	$150 copay, then 100% - copay waived if admitted	
Non-Emergency use of an Emergency Room	Plan pays 80% after deductible	Plan pays 60% after deductible

Benefit	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	Plan pays 80% after deductible	Plan pays 60% after deductible
Maternity	Plan pays 80% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility	Plan pays 80% after deductible	Plan pays 60% after deductible
Additional Services		
Allergy Testing and Treatments	Plan pays 80% after deductible	Plan pays 60% after deductible
Ambulance	Plan pays 80% after deductible	Plan pays 60% after deductible
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible
Home Healthcare (40 visits per benefit period)	Plan pays 80% after deductible	Plan pays 60% after deductible
Hospice	Plan pays 80% after deductible	Plan pays 60% after deductible
Organ Transplants ($10,000 maximum for patient transportation)	Plan pays 80% after deductible	Plan pays 60% after deductible
Private Duty Nursing	Plan pays 80% after deductible	Plan pays 60% after deductible
Mental Health and Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid based on corresponding medical benefits**	
Outpatient Mental Health and Substance Abuse		

Note: Services requiring a copayment are not subject to the single/family deductible or coinsurance.

Deductible and coinsurance expenses incurred for services by a non-network provider will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a network provider will also apply to the non-network deductible and coinsurance out-of pocket limits.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or benefit booklet will contain the complete listing of covered services. The covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

Save on SP:

MEDICAL MUTUAL
CAROLINA CARE PLAN | CONSUMERS LIFE

EXPRESS SCRIPTS®

COUNTY OF SUMMIT PRESCRIPTION SUMMARY
ADVANTAGE AND MEDFLEX PLAN

	Network Retail Pharmacy	Smart90 Options Pharmacies	Mail Service Pharmacy
	For immediate medication needs	For immediate and maintenance medication** needs	
Up to a 31-day supply:	Generic: **$10** Brand Formulary with no generic available: **$25** Brand formulary with generic available**: $25 plus the cost difference between the brand and the generic cost** Brand Non-Formulary with no generic available: **$50** Brand Non -Formulary with generic available**: $50 plus the cost difference between the brand and the generic cost**	Generic: **$10** Brand Formulary with no generic available: **$25** Brand formulary with generic available**: $25 plus the cost difference between the brand and the generic cost** Brand Non-Formulary with no generic available: **$50** Brand Non -Formulary with generic available**: $50 plus the cost difference between the brand and the generic cost**	Generic: **$20** Brand Formulary with no generic available: **$50** Brand formulary with generic available**: $50 plus the cost difference between the brand and the generic cost** Brand Non-Formulary with no generic available: **$100** Brand Non -Formulary with generic available**: $100 plus the cost difference between the brand and the generic cost**
90-day supply	**Not Available**	Generic: **$20** Brand Formulary with no generic available: **$50** Brand formulary with generic available**: $50 plus the cost difference between the brand and the generic cost** Brand Non-Formulary with no generic available: **$100** Brand Non -Formulary with generic available**: $100 plus the cost difference between the brand and the generic cost**	

**Maintenance medications are prescribed for chronic, long-term conditions (such as diabetes, high blood pressure, high cholesterol and seizure disorders). All maintenance medications will be required to be filled for a 90-day supply and filled through Express Scripts/Medco Mail Order Pharmacy or the Smart90 Options program. You will be allowed to get 2 fills of your maintenance medications filled at a retail pharmacy and then all subsequent refills must be written for a 90-day supply and filled through Express Scripts Mail Order Pharmacy or the Smart90 Options program.

If enrolling in the Mail Order program, employees must obtain a 90-day prescription, complete the Mail Order Form and return it to Express Scripts to receive prescriptions by mail. To receive mail order prescriptions employees must include original prescriptions with the Mail Order Form. If utilizing the Smart90 Options program, employees must choose a pharmacy participating in the Smart90 program. Employees must obtain a new 90-day prescription from their physician and take it to the participating pharmacy.

Choose what is more convenient for you. The copayment is the same either way.

With the Smart90 Options program:

- Pick-up your maintenance medication directly from the pharmacy at a time that is convenient for you
- Enjoy same-day prescription availability
- Talk face-to-face with a pharmacist

With Express Scripts/Medco Mail Service:

- Receive medication in confidential, tamper-resistant and (when necessary) temperature-controlled packaging
- Enjoy convenient home delivery
- Talk to a pharmacist by phone

Once in the Mail Order System, visit www.medmutual.com to refill your medications online or call toll-free 1-800-417-1961. To learn more about your prescription benefit plan, obtain preferred drug list, investigate other cost savings opportunities and access medication and health information visit www.medmutual.com or call 1-800-417-1961.

This document is only a partial listing of benefits.

Includes: Some over-the-counter items, as well as insulin, syringes and needles, glucose monitors, meters or glucowatch, Blood or Blood Plasma product, Weight Loss Drugs, Smoking Cessation (except patches), Erectile Dysfunction (ED) drugs will be limited to 8 pills under Retail and 24 pills under Mail Service, Prior Auth programs edits will apply, except for ED drugs – see above for ED coverage

Excludes: Allergy Serum, Nutritional Supplements, Fertility Medications.

ILENE SHAPIRO
COUNTY EXECUTIVE

County of Summit
Medical Mutual of Ohio
Minimum Value Plan

SuperMed Plus®

Benefit	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age	Age 26 - Removal upon end of month of 26th birthday	
Pre-Existing Condition Waiting Period	None	
Lifetime Maximum	Unlimited	
Benefit Period Deductible – Single/Family	$4000 / $8,000	$8,000/ $16,000
Coinsurance	Plan pays 70%; Member pays 30% up to $2,350/$4,700	Plan pays 50%; Member pays 50% up to $4,700/$9,400
Maximum Out-of-Pocket (incudes Deductible and Coinsurance) Single/Family	$6,350 / $12,700	$12,700 / $25,400
Physician/Office Services		
Office Visit (Illness/Injury)	Plan pays 70% after deductible	Plan pays 50% after deductible
Urgent Care Office Visit	Plan pays 70% after deductible	Plan pays 50% after deductible
All Immunizations	Plan pays 100%	Plan pays 50% after deductible
Preventive Services		
Preventive Services, in accordance with state and federal law	Plan pays 100%	Plan pays 50% after deductible
Preventive Physical Exam (Ages 21 and over)	Plan pays 100%	Plan pays 50% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations (To age 21)	Plan pays 100%	Plan pays 50% after deductible
Preventive Mammogram (One per benefit period)	Plan pays 100%	Plan pays 50% after deductible
Preventive Pap Test (One per benefit period)	Plan pays 100%	Plan pays 50% after deductible
Preventive Lab, X-Ray and Medical Tests	Plan pays 100%	Plan pays 50% after deductible
Preventive Endoscopic Services	Plan pays 100%	Plan pays 50% after deductible
Preventive Eye Exam (one per benefit period)	Plan pays 70% after deductible	Plan pays 50% after deductible
Preventive Eye Refraction (one per 24 months)	Plan pays 70% after deductible	Plan pays 50% after deductible
Outpatient Services		
Surgical Services	Plan pays 70% after deductible	Plan pays 50% after deductible
Diagnostic Services - X-Ray, Medical Tests	Plan pays 70% after deductible	Plan pays 50% after deductible
Diagnostic Lab	Plan pays 70% after deductible	Plan pays 50% after deductible
Diagnostic and Routine Prostate Specific Antigen (PSA)	Plan pays 70% after deductible	Plan pays 50% after deductible
Physical Therapy (25 visits combined with Occupational Therapy then subject to Med Review)	Plan pays 70% after deductible	Plan pays 50% after deductible
Occupational Therapy (25 visits combined with Physical Therapy then subject to Med Review)	Plan pays 70% after deductible	Plan pays 50% after deductible
Chiropractic Therapy (25 visits then subject to Med Review)	Plan pays 70% after deductible	Plan pays 50% after deductible
Speech Therapy (10 visits then subject to Med Review)	Plan pays 70% after deductible	Plan pays 50% after deductible
Cardiac Rehabilitation	Plan pays 70% after deductible	Plan pays 50% after deductible
Emergency use of an Emergency Room	Plan pays 70% after deductible	
Non-Emergency use of an Emergency Room	Plan pays 70% after deductible	Plan pays 50% after deductible

Benefit	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	Plan pays 70% after deductible	Plan pays 50% after deductible
Maternity	Plan pays 70% after deductible	Plan pays 50% after deductible
Skilled Nursing Facility	Plan pays 70% after deductible	Plan pays 50% after deductible
Additional Services		
Injectable Contraceptives and Contraceptive Devices	Plan pays 70% after deductible	Plan pays 50% after deductible
Allergy Testing and Treatments	Plan pays 70% after deductible	Plan pays 50% after deductible
Ambulance	Plan pays 70% after deductible	Plan pays 50% after deductible
Durable Medical Equipment	Plan pays 70% after deductible	Plan pays 50% after deductible
Home Healthcare (40 visits per benefit period)	Plan pays 70% after deductible	Plan pays 50% after deductible
Hospice	Plan pays 70% after deductible	Plan pays 50% after deductible
Organ Transplants ($10,000 maximum for patient transportation)	Plan pays 70% after deductible	Plan pays 50% after deductible
Private Duty Nursing	Plan pays 70% after deductible	Plan pays 50% after deductible
Mental Health and Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid based on corresponding medical benefits**	
Outpatient Mental Health and Substance Abuse		

Note: Deductible and coinsurance expenses incurred for services by a non-network provider will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a network provider will also apply to the non-network deductible and coinsurance out-of pocket limits.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or benefit booklet will contain the complete listing of covered services. The covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

DavisVision™

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

County of Summit your vision plan

Client code: 2968

Frequency

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

Sign up during open enrollment

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

Exams & Services

Eye Exam copay:
$15

Contacts evaluation, fitting & follow-up:

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

Lenses

Lens copay:
$15

Frame

Allowance:

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

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

or

The Exclusive Collection copay:

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

Contacts[3] in lieu of glasses

Allowance:

$100

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

or

The Exclusive Collection of Contact Lenses:[4]

Covered in full

Using your client code

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

The Exclusive Collection

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

Free breakage warranty

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

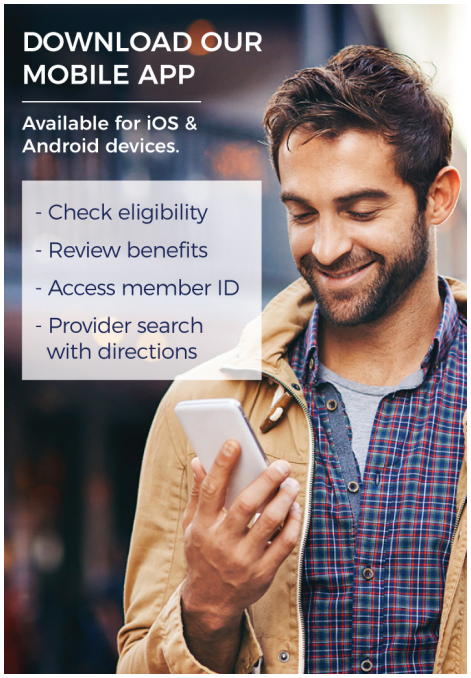
Find a network provider...

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

Options & upgrades

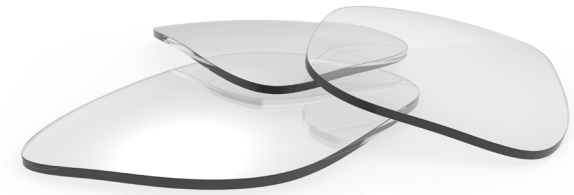
Lens options

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



Additional savings

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



Out-of-network benefits

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

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

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

Guardian

Group Number: 00543971

COUNTY OF SUMMIT

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Dental

Guardian

COUNTY OF SUMMIT

Dental Benefit Summary

Group Number: 00543971

A Dental insurance plan through Guardian:

- Provides coverage for key preventive services such as regular checkups and cleanings to keep you and your family healthy
- Helps offset potentially expensive dental procedures, such as crowns and fillings
- Gives you access to one of the nation's largest dental networks so care is convenient to you
- Makes it easy to find a high quality certified network dentist by accessing guardiananytime.com or Guardian's find a provider mobile app
- Fast and easy claim payments

About Your Benefits:

Option 1: Value Plan plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

Option 2: PPO Plan plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**Option 1: Value Plan**		**Option 2: PPO Plan**	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Bi-weekly premium	**$14.41**		**$14.41**	
You, Spouse/Domestic Partner and Child(ren)	$42.71		$42.71	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$50	$50	$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%	100%	100%
Basic Care	100%	100%	80%	80%
Major Care	60%	60%	50%	50%
Orthodontia	50%	50%	50%	50%
Annual Maximum Benefit	$1500	$1500	$1500	$1500
Maximum Rollover	Yes		Yes	
Rollover Threshold	$700		$700	
Rollover Amount	$350		$350	
Rollover In-network Amount	$500		$500	
Rollover Account Limit	$1250		$1250	
Lifetime Orthodontia Maximum	$1500		$1500	
Dependent Age Limits	26		26	

A Sample of Services Covered by Your Plan:

		Option 1: Value Plan *Plan pays (on average)*		Option 2: PPO Plan *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	No Age Limits		No Age Limits	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	100%	100%	80%	80%
	Fillings‡	100%	100%	80%	80%
	Perio Surgery	100%	100%	80%	80%
	Periodontal Maintenance	100%	100%	80%	80%
	Frequency:	2 per calendar year		2 per calendar year	
	Repair & Maintenance of Crowns, Bridges & Dentures	100%	100%	80%	80%
	Root Canal	100%	100%	80%	80%
	Scaling & Root Planing (per quadrant)	100%	100%	80%	80%
	Simple Extractions	100%	100%	80%	80%
	Surgical Extractions	100%	100%	80%	80%
Major Care	Bridges and Dentures	60%	60%	50%	50%
	Dental Implants	60%	60%	50%	50%
	Inlays, Onlays, Veneers**	60%	60%	50%	50%
	Single Crowns	60%	60%	50%	50%
Orthodontia	Orthodontia	50%	50%	50%	50%
	Limits:	Child(ren)		Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

Guardian Choice – *Additional Details*

You have the flexibility to choose the plan that can best meet your needs.

Both plans can meet your needs; the difference is how out-of-network benefits are reimbursed.

Here's how this benefit works:
Premiums are the same for either plan
Option to switch plans each year at annual enrollment time
Save an average of 30% over what dentists usually charge by using network providers

	Value Plan	Network Access Plan
Plan Description:	Benefits are paid at the same coinsurance percentages in-network and out-of-network. When you seek in-network care, you receive our PPO savings and you'll have less out of pocket costs	Benefits are paid at the same coinsurance percentages in-network and out-of-network. You retain complete freedom of choice to see any dentist in or out-of-network.
In-network:	Benefits are based on a negotiated contracted fee schedule (an average discount of 30%). No additional fees to the dentist!	
Out-of-network:	• Benefits are based on the discounted fee schedules agreed upon by our network dentists. • **Any amount that is charged over the fee schedule is the responsibility of the patient.**	• Benefits are based on usual, customary and reasonable (UCR) charges that dentists in your area charge for each procedure.
Co-insurance:	• Preventive services are covered 100%. • Co-insurance for other services is higher than the Network Access Plan.	• Preventive services are covered 100%. • Co-insurance for other services is lower than the Value Plan.

To find a dentist, visit www.GuardianAnytime.com or download our Guardian Anytime mobile app.

For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage." Policy Form #GP-1-DG2000, et al.

Finding a dentist is easy

Go online – it just takes minutes!

The best way to save money through your dental plan is by seeing a dentist in your plan's network. Guardian's Find a Provider site makes it easy for you to search for a dentist that meets your needs.

Guardian's Find a Provider site is available to you 24 hours a day, 7 days a week.

- Customize your search by specialty, languages spoken and more
- Get side-by-side comparisons of dentists' information (ie. office status, distance)
- Create a quick-list of "favorite" dentists — for easy reference online
- Get maps and directions to a dentist's office location
- View your results online or have them faxed or emailed to you
- Save your search criteria for easy access when you revisit the site
- Create a customized directory of dentists
- Nominate a dentist to be included in a network
- And much more!

Just go to www.GuardianAnytime.com and click on "Find a Provider". You can also find a dentist on the go from your smart phone – simply download our app.

Welcome to the College Tuition Benefits Rewards program! Your Plan Sponsor has worked with Guardian to make College Tuition Benefit services available to eligible participants enrolling in the following coverage/option(s):

Coverage	Option
Dental	Option 1: Value Plan Option 2: PPO Plan

Register Today!

You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at over 380 private colleges and universities across the nation. In 2016, over $60 million in College Tuition Benefit Rewards were submitted by high school seniors. **Here is how it works:**

- Annual enrollment in this plan earns you 2,000 Tuition Rewards (1 Reward = $1 in tuition reduction at a network of Private Colleges and Universities) for each line of Guardian coverage (up to four lines).
- Guardian Dental participants receive a bonus after year four.
- These rewards are yours for your lifetime and can be given to children, grandchildren, nieces, nephews and godchildren.

The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian.

Print and cut out ID Card

College Tuition Benefits Rewards- ID Card

Register@
www.Guardian.CollegeTuitionBenefit.com

User ID: Is Your Guardian Group Plan Number that can be found on your benefit booklet
Password: Guardian

fold

The College Tuition Benefit
435 Devon Park Drive
Building 400, Suite 410
Wayne, PA 19087
Phone:(215) 839-0119
Fax: (215) 392-3255

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

Please print clearly and mark carefully.

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

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

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

About You:

First, MI, Last Name:

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

Address | City | State | Zip

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

Email Address:

Are you married or do you have a spouse? ❑ Yes ❑ No
Do you have children or other dependents? ❑ Yes ❑ No

Date of marriage/union:____-____-_____
Placement date of adopted child: ____-____-_____

Voluntary Term Life Coverage:

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

Employee

Policy Amount *Check one box only*

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

*Guarantee Issue Amount.

❑ I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

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

**Guarantee Issue Amount*

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

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ $5,000*

**Guarantee Issue Amount*

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

❑ I do not want this coverage

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

Employee Yes ❑ No ❑ | Spouse Yes ❑ No ❑

Important Notes:

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

LIFE INSURANCE *continued*

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

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Accidental Death and Dismemberment Coverage:

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

Employee Only

Policy Amount

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

❑ I do not want this coverage

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

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

❑ I do not want this coverage

Signature

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

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

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

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

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ DATE _____

Guardian

Group Number: 00576937

COUNTY OF SUMMIT

VOLUNTARY LIFE

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Life

THIS PAGE INTENTIONALLY LEFT BLANK

Guardian

COUNTY OF SUMMIT

Group Number: 00576937

Life Benefit Summary

A Life insurance plan through Guardian provides:

- The foundation of a smart financial plan that helps protect you and those who depend on you
- Affordable group rates
- Flexibility to update your coverage as your life changes or take it with you if you change jobs or retire

About Your Benefits:

	VOLUNTARY TERM LIFE
Employee Benefit **(Employee must elect coverage for spouse and dependents to be eligible)**	$10,000 increments to a maximum of $300,000. See Cost Illustration page for details.
Spouse Benefit	$5,000 increments to a maximum of $150,000, not to exceed 50% of the employee amount. See Cost Illustration page for details.
Child Benefit+	Your dependent children age 14 days to 26 years. You may elect one of the following benefit options: $5,000. Subject to state limits. See Cost Illustration page for details.
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 the initial enrollment period.	We Guarantee Issue coverage up to: Employee $300,000. At age 70 $50,000. Spouse $50,000. Dependent children $5,000.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	Totally disabled prior to age 60, insurance will continue until SSNRA or no longer disabled, 6 month EP.
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 70, 55% at age 75, 70% at age 80, 80% at age 85, 85% at age 90

Subject to coverage limits

+ Voluntary Life: Infant coverage is limited based on age.

Annual Election Option allows the 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.

Manage Your Benefits:

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

Benefit information illustrated within this material reflects the plan covered by Guardian as of 09/08/2020

VOLUNTARY LIFE Benefit Summary

The Guardian Life Insurance Company of America, New York, NY

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and view a video: https://www.guardiananytime.com/gafd/wps/portal/fdhome/employees/products-coverage/life

Monthly premiums displayed.

Policy Election Cost Per Age Bracket

Employee	Policy Amounts		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-99
	$10,000.00	Preferred	$0.65	$0.80	$1.02	$1.67	$2.41	$4.07	$6.98	$10.97	$17.34	$27.71
		Standard	$1.24	$1.31	$1.74	$2.91	$5.31	$8.59	$15.56	$19.04	$30.60	$48.62
	$20,000.00	Preferred	$1.30	$1.60	$2.04	$3.34	$4.82	$8.14	$13.96	$21.94	$34.68	$55.42
		Standard	$2.48	$2.62	$3.48	$5.82	$10.62	$17.18	$31.12	$38.08	$61.20	$97.24
	$30,000.00	Preferred	$1.95	$2.40	$3.06	$5.01	$7.23	$12.21	$20.94	$32.91	$52.02	$83.13
		Standard	$3.72	$3.93	$5.22	$8.73	$15.93	$25.77	$46.68	$57.12	$91.80	$145.86
	$40,000.00	Preferred	$2.60	$3.20	$4.08	$6.68	$9.64	$16.28	$27.92	$43.88	$69.36	$110.84
		Standard	$4.96	$5.24	$6.96	$11.64	$21.24	$34.36	$62.24	$76.16	$122.40	$194.48
	$50,000.00	Preferred	$3.25	$4.00	$5.10	$8.35	$12.05	$20.35	$34.90	$54.85	$86.70	$138.55
		Standard	$6.20	$6.55	$8.70	$14.55	$26.55	$42.95	$77.80	$95.20	$153.00	$243.10
	$60,000.00	Preferred	$3.90	$4.80	$6.12	$10.02	$14.46	$24.42	$41.88	$65.82	$104.04	$166.26
		Standard	$7.44	$7.86	$10.44	$17.46	$31.86	$51.54	$93.36	$114.24	$183.60	$291.72
	$70,000.00	Preferred	$4.55	$5.60	$7.14	$11.69	$16.87	$28.49	$48.86	$76.79	$121.38	$193.97
		Standard	$8.68	$9.17	$12.18	$20.37	$37.17	$60.13	$108.92	$133.28	$214.20	$340.34
	$80,000.00	Preferred	$5.20	$6.40	$8.16	$13.36	$19.28	$32.56	$55.84	$87.76	$138.72	$221.68
		Standard	$9.92	$10.48	$13.92	$23.28	$42.48	$68.72	$124.48	$152.32	$244.80	$388.96
	$90,000.00	Preferred	$5.85	$7.20	$9.18	$15.03	$21.69	$36.63	$62.82	$98.73	$156.06	$249.39
		Standard	$11.16	$11.79	$15.66	$26.19	$47.79	$77.31	$140.04	$171.36	$275.40	$437.58
	$100,000.00	Preferred	$6.50	$8.00	$10.20	$16.70	$24.10	$40.70	$69.80	$109.70	$173.40	$277.10
		Standard	$12.40	$13.10	$17.40	$29.10	$53.10	$85.90	$155.60	$190.40	$306.00	$486.20
	$110,000.00	Preferred	$7.15	$8.80	$11.22	$18.37	$26.51	$44.77	$76.78	$120.67	$190.74	$304.81
		Standard	$13.64	$14.41	$19.14	$32.01	$58.41	$94.49	$171.16	$209.44	$336.60	$534.82
	$120,000.00	Preferred	$7.80	$9.60	$12.24	$20.04	$28.92	$48.84	$83.76	$131.64	$208.08	$332.52
		Standard	$14.88	$15.72	$20.88	$34.92	$63.72	$103.08	$186.72	$228.48	$367.20	$583.44
	$130,000.00	Preferred	$8.45	$10.40	$13.26	$21.71	$31.33	$52.91	$90.74	$142.61	$225.42	$360.23
		Standard	$16.12	$17.03	$22.62	$37.83	$69.03	$111.67	$202.28	$247.52	$397.80	$632.06
	$140,000.00	Preferred	$9.10	$11.20	$14.28	$23.38	$33.74	$56.98	$97.72	$153.58	$242.76	$387.94
		Standard	$17.36	$18.34	$24.36	$40.74	$74.34	$120.26	$217.84	$266.56	$428.40	$680.68
	$150,000.00	Preferred	$9.75	$12.00	$15.30	$25.05	$36.15	$61.05	$104.70	$164.55	$260.10	$415.65
		Standard	$18.60	$19.65	$26.10	$43.65	$79.65	$128.85	$233.40	$285.60	$459.00	$729.30
	$160,000.00	Preferred	$10.40	$12.80	$16.32	$26.72	$38.56	$65.12	$111.68	$175.52	$277.44	$443.36
		Standard	$19.84	$20.96	$27.84	$46.56	$84.96	$137.44	$248.96	$304.64	$489.60	$777.92
	$170,000.00	Preferred	$11.05	$13.60	$17.34	$28.39	$40.97	$69.19	$118.66	$186.49	$294.78	$471.07
		Standard	$21.08	$22.27	$29.58	$49.47	$90.27	$146.03	$264.52	$323.68	$520.20	$826.54
	$180,000.00	Preferred	$11.70	$14.40	$18.36	$30.06	$43.38	$73.26	$125.64	$197.46	$312.12	$498.78
		Standard	$22.32	$23.58	$31.32	$52.38	$95.58	$154.62	$280.08	$342.72	$550.80	$875.16
	$190,000.00	Preferred	$12.35	$15.20	$19.38	$31.73	$45.79	$77.33	$132.62	$208.43	$329.46	$526.49
		Standard	$23.56	$24.89	$33.06	$55.29	$100.89	$163.21	$295.64	$361.76	$581.40	$923.78
	$200,000.00	Preferred	$13.00	$16.00	$20.40	$33.40	$48.20	$81.40	$139.60	$219.40	$346.80	$554.20
		Standard	$24.80	$26.20	$34.80	$58.20	$106.20	$171.80	$311.20	$380.80	$612.00	$972.40
	$210,000.00	Preferred	$13.65	$16.80	$21.42	$35.07	$50.61	$85.47	$146.58	$230.37	$364.14	$581.91
		Standard	$26.04	$27.51	$36.54	$61.11	$111.51	$180.39	$326.76	$399.84	$642.60	$1,021.02
	$220,000.00	Preferred	$14.30	$17.60	$22.44	$36.74	$53.02	$89.54	$153.56	$241.34	$381.48	$609.62
		Standard	$27.28	$28.82	$38.28	$64.02	$116.82	$188.98	$342.32	$418.88	$673.20	$1,069.64

VOLUNTARY LIFE SUMMARY Benefit Summary

The Guardian Life Insurance Company of America, New York, NY

Voluntary Life Cost Illustration *continued*

	$230,000.00	Preferred	$14.95	$18.40	$23.46	$38.41	$55.43	$93.61	$160.54	$252.31	$398.82	$637.33
		Standard	$28.52	$30.13	$40.02	$66.93	$122.13	$197.57	$357.88	$437.92	$703.80	$1,118.26
	$240,000.00	Preferred	$15.60	$19.20	$24.48	$40.08	$57.84	$97.68	$167.52	$263.28	$416.16	$665.04
		Standard	$29.76	$31.44	$41.76	$69.84	$127.44	$206.16	$373.44	$456.96	$734.40	$1,166.88
	$250,000.00	Preferred	$16.25	$20.00	$25.50	$41.75	$60.25	$101.75	$174.50	$274.25	$433.50	$692.75
		Standard	$31.00	$32.75	$43.50	$72.75	$132.75	$214.75	$389.00	$476.00	$765.00	$1,215.50
	$260,000.00	Preferred	$16.90	$20.80	$26.52	$43.42	$62.66	$105.82	$181.48	$285.22	$450.84	$720.46
		Standard	$32.24	$34.06	$45.24	$75.66	$138.06	$223.34	$404.56	$495.04	$795.60	$1,264.12
	$270,000.00	Preferred	$17.55	$21.60	$27.54	$45.09	$65.07	$109.89	$188.46	$296.19	$468.18	$748.17
		Standard	$33.48	$35.37	$46.98	$78.57	$143.37	$231.93	$420.12	$514.08	$826.20	$1,312.74
	$280,000.00	Preferred	$18.20	$22.40	$28.56	$46.76	$67.48	$113.96	$195.44	$307.16	$485.52	$775.88
		Standard	$34.72	$36.68	$48.72	$81.48	$148.68	$240.52	$435.68	$533.12	$856.80	$1,361.36
	$290,000.00	Preferred	$18.85	$23.20	$29.58	$48.43	$69.89	$118.03	$202.42	$318.13	$502.86	$803.59
		Standard	$35.96	$37.99	$50.46	$84.39	$153.99	$249.11	$451.24	$552.16	$887.40	$1,409.98
	$300,000.00	Preferred	$19.50	$24.00	$30.60	$50.10	$72.30	$122.10	$209.40	$329.10	$520.20	$831.30
		Standard	$37.20	$39.30	$52.20	$87.30	$159.30	$257.70	$466.80	$571.20	$918.00	$1,458.60

Spouse	Policy Amounts		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-99
	$5,000.00	Preferred	$0.33	$0.40	$0.51	$0.84	$1.21	$2.04	$3.49	$5.49	$8.67	$13.86
		Standard	$0.62	$0.66	$0.87	$1.46	$2.66	$4.30	$7.78	$9.52	$15.30	$24.31
	$10,000.00	Preferred	$0.65	$0.80	$1.02	$1.67	$2.41	$4.07	$6.98	$10.97	$17.34	$27.71
		Standard	$1.24	$1.31	$1.74	$2.91	$5.31	$8.59	$15.56	$19.04	$30.60	$48.62
	$15,000.00	Preferred	$0.98	$1.20	$1.53	$2.51	$3.62	$6.11	$10.47	$16.46	$26.01	$41.57
		Standard	$1.86	$1.97	$2.61	$4.37	$7.97	$12.89	$23.34	$28.56	$45.90	$72.93
	$20,000.00	Preferred	$1.30	$1.60	$2.04	$3.34	$4.82	$8.14	$13.96	$21.94	$34.68	$55.42
		Standard	$2.48	$2.62	$3.48	$5.82	$10.62	$17.18	$31.12	$38.08	$61.20	$97.24
	$25,000.00	Preferred	$1.63	$2.00	$2.55	$4.18	$6.03	$10.18	$17.45	$27.43	$43.35	$69.28
		Standard	$3.10	$3.28	$4.35	$7.28	$13.28	$21.48	$38.90	$47.60	$76.50	$121.55
	$30,000.00	Preferred	$1.95	$2.40	$3.06	$5.01	$7.23	$12.21	$20.94	$32.91	$52.02	$83.13
		Standard	$3.72	$3.93	$5.22	$8.73	$15.93	$25.77	$46.68	$57.12	$91.80	$145.86
	$35,000.00	Preferred	$2.28	$2.80	$3.57	$5.85	$8.44	$14.25	$24.43	$38.40	$60.69	$96.99
		Standard	$4.34	$4.59	$6.09	$10.19	$18.59	$30.07	$54.46	$66.64	$107.10	$170.17
	$40,000.00	Preferred	$2.60	$3.20	$4.08	$6.68	$9.64	$16.28	$27.92	$43.88	$69.36	$110.84
		Standard	$4.96	$5.24	$6.96	$11.64	$21.24	$34.36	$62.24	$76.16	$122.40	$194.48
	$45,000.00	Preferred	$2.93	$3.60	$4.59	$7.52	$10.85	$18.32	$31.41	$49.37	$78.03	$124.70
		Standard	$5.58	$5.90	$7.83	$13.10	$23.90	$38.66	$70.02	$85.68	$137.70	$218.79
	$50,000.00	Preferred	$3.25	$4.00	$5.10	$8.35	$12.05	$20.35	$34.90	$54.85	$86.70	$138.55
		Standard	$6.20	$6.55	$8.70	$14.55	$26.55	$42.95	$77.80	$95.20	$153.00	$243.10
	$55,000.00	Preferred	$3.58	$4.40	$5.61	$9.19	$13.26	$22.39	$38.39	$60.34	$95.37	$152.41
		Standard	$6.82	$7.21	$9.57	$16.01	$29.21	$47.25	$85.58	$104.72	$168.30	$267.41
	$60,000.00	Preferred	$3.90	$4.80	$6.12	$10.02	$14.46	$24.42	$41.88	$65.82	$104.04	$166.26
		Standard	$7.44	$7.86	$10.44	$17.46	$31.86	$51.54	$93.36	$114.24	$183.60	$291.72
	$65,000.00	Preferred	$4.23	$5.20	$6.63	$10.86	$15.67	$26.46	$45.37	$71.31	$112.71	$180.12
		Standard	$8.06	$8.52	$11.31	$18.92	$34.52	$55.84	$101.14	$123.76	$198.90	$316.03
	$70,000.00	Preferred	$4.55	$5.60	$7.14	$11.69	$16.87	$28.49	$48.86	$76.79	$121.38	$193.97
		Standard	$8.68	$9.17	$12.18	$20.37	$37.17	$60.13	$108.92	$133.28	$214.20	$340.34

Voluntary Life Cost Illustration *continued*

	$75,000.00	Preferred	$4.88	$6.00	$7.65	$12.53	$18.08	$30.53	$52.35	$82.28	$130.05	$207.83
		Standard	$9.30	$9.83	$13.05	$21.83	$39.83	$64.43	$116.70	$142.80	$229.50	$364.65
	$80,000.00	Preferred	$5.20	$6.40	$8.16	$13.36	$19.28	$32.56	$55.84	$87.76	$138.72	$221.68
		Standard	$9.92	$10.48	$13.92	$23.28	$42.48	$68.72	$124.48	$152.32	$244.80	$388.96
	$85,000.00	Preferred	$5.53	$6.80	$8.67	$14.20	$20.49	$34.60	$59.33	$93.25	$147.39	$235.54
		Standard	$10.54	$11.14	$14.79	$24.74	$45.14	$73.02	$132.26	$161.84	$260.10	$413.27
	$90,000.00	Preferred	$5.85	$7.20	$9.18	$15.03	$21.69	$36.63	$62.82	$98.73	$156.06	$249.39
		Standard	$11.16	$11.79	$15.66	$26.19	$47.79	$77.31	$140.04	$171.36	$275.40	$437.58
	$95,000.00	Preferred	$6.18	$7.60	$9.69	$15.87	$22.90	$38.67	$66.31	$104.22	$164.73	$263.25
		Standard	$11.78	$12.45	$16.53	$27.65	$50.45	$81.61	$147.82	$180.88	$290.70	$461.89
	$100,000.00	Preferred	$6.50	$8.00	$10.20	$16.70	$24.10	$40.70	$69.80	$109.70	$173.40	$277.10
		Standard	$12.40	$13.10	$17.40	$29.10	$53.10	$85.90	$155.60	$190.40	$306.00	$486.20
	$105,000.00	Preferred	$6.83	$8.40	$10.71	$17.54	$25.31	$42.74	$73.29	$115.19	$182.07	$290.96
		Standard	$13.02	$13.76	$18.27	$30.56	$55.76	$90.20	$163.38	$199.92	$321.30	$510.51
	$110,000.00	Preferred	$7.15	$8.80	$11.22	$18.37	$26.51	$44.77	$76.78	$120.67	$190.74	$304.81
		Standard	$13.64	$14.41	$19.14	$32.01	$58.41	$94.49	$171.16	$209.44	$336.60	$534.82
	$115,000.00	Preferred	$7.48	$9.20	$11.73	$19.21	$27.72	$46.81	$80.27	$126.16	$199.41	$318.67
		Standard	$14.26	$15.07	$20.01	$33.47	$61.07	$98.79	$178.94	$218.96	$351.90	$559.13
	$120,000.00	Preferred	$7.80	$9.60	$12.24	$20.04	$28.92	$48.84	$83.76	$131.64	$208.08	$332.52
		Standard	$14.88	$15.72	$20.88	$34.92	$63.72	$103.08	$186.72	$228.48	$367.20	$583.44
	$125,000.00	Preferred	$8.13	$10.00	$12.75	$20.88	$30.13	$50.88	$87.25	$137.13	$216.75	$346.38
		Standard	$15.50	$16.38	$21.75	$36.38	$66.38	$107.38	$194.50	$238.00	$382.50	$607.75
	$130,000.00	Preferred	$8.45	$10.40	$13.26	$21.71	$31.33	$52.91	$90.74	$142.61	$225.42	$360.23
		Standard	$16.12	$17.03	$22.62	$37.83	$69.03	$111.67	$202.28	$247.52	$397.80	$632.06
	$135,000.00	Preferred	$8.78	$10.80	$13.77	$22.55	$32.54	$54.95	$94.23	$148.10	$234.09	$374.09
		Standard	$16.74	$17.69	$23.49	$39.29	$71.69	$115.97	$210.06	$257.04	$413.10	$656.37
	$140,000.00	Preferred	$9.10	$11.20	$14.28	$23.38	$33.74	$56.98	$97.72	$153.58	$242.76	$387.94
		Standard	$17.36	$18.34	$24.36	$40.74	$74.34	$120.26	$217.84	$266.56	$428.40	$680.68
	$145,000.00	Preferred	$9.43	$11.60	$14.79	$24.22	$34.95	$59.02	$101.21	$159.07	$251.43	$401.80
		Standard	$17.98	$19.00	$25.23	$42.20	$77.00	$124.56	$225.62	$276.08	$443.70	$704.99
	$150,000.00	Preferred	$9.75	$12.00	$15.30	$25.05	$36.15	$61.05	$104.70	$164.55	$260.10	$415.65
		Standard	$18.60	$19.65	$26.10	$43.65	$79.65	$128.85	$233.40	$285.60	$459.00	$729.30

Child(ren)	Policy Amounts	Premium
	$5,000.00	$1.00

Spouse rate is based on Employee age. The tobacco status is based on Employee and Spouse independently.
Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
Infant coverage is limited for the first two weeks of infant's life.
†Benefit reductions apply.
Preferred rates apply to premium for non-tobacco usage. Standard rates apply to premium for tobacco usage.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

WillPrep Services

Special bonus for participants in voluntary life plan

Your employer has worked with Guardian to make WillPrep Services available to eligible members with Voluntary Life plans. Keeping an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate. You may be avoiding creating a will because you believe you can't afford the time or legal expense. Now you can with WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professionals* to help with issues related to:

▪ Advanced Health Care Directives	▪ Financial Power of Attorney	▪ Wills and Living Wills
▪ Estate Taxes	▪ Guardianship and Conservatorship	▪ Resource Library
▪ Executors & Probate	▪ Healthcare Power of Attorney	▪ Trusts

For more information about WillPrep Services, go to www.ibhwillprep.com; User name: WillPrep; Password: GLIC09 or call 1-877-433-6789

*The Option of an attorney prepared will is available for a small fee.

WillPrep Services are provided by Integrated Behavioral Health, Inc., and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of *WillPrep Services*. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the *WillPrep Services* at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

Guardian®

Easy-To-Use Online Link Provides Faster Processing

Guardian's online electronic Evidence of Insurability (EOI) provides an alternative to paper EOI forms when you need to provide additional information for requested coverage.

Common situations include:

- Answering yes to one of the health questions on your enrollment form
- Enrolling for coverage in excess of the guaranteed issue amount
- Requesting coverage after your initial eligibility for coverage

Electronic Evidence of Insurability can be used for the following coverages*:

- Basic Life
- Voluntary Life
- Short Term Disability
- Long Term Disability

Guardian's online EOI form offers several advantages:

- Your personal data is kept secure
- No errors due to hand-written data
- Faster submission of your completed form

Accessing the electronic Evidence of Insurability link

Simply go to : guardiananytime.com/eoi

No registration is required. The process is easy and secure, simply follow the steps outlined below:

1. Fill in your Group ID #
2. Enter your personal information
3. Answer the health questions
4. Electronically sign your name and click 'Submit'

Guardian receives the completed EOI form in minutes!

1. Guardian's Medical Underwriting Team moves through the EOI process and will contact you with any questions.
2. We will send you a letter in the mail regarding the status of your request for coverage.
3. We will notify your employer of the outcome of your request only if your coverage amount is changed.

If you have questions about the process or if you need to provide evidence of insurability, please contact your Plan Administrator.

The Guardian Life Insurance Company of America
New York, NY

guardiananytime.com

*Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts). Electronic EOI is not available in New York and New Hampshire. Electronic EOI is available using most internet browsers.

Guardian® is a registered service mark of The Guardian Life Insurance Company of America.

2019-78551 (04-21)

Guardian

Group Number: 00576937

COUNTY OF SUMMIT

VOLUNTARY AD&D

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Voluntary Accidental Death and Dismemberment

THIS PAGE INTENTIONALLY LEFT BLANK

Guardian

COUNTY OF SUMMIT

Accidental Death and Dismemberment Benefit Summary

Group Number: 00576937

An Accidental Death & Dismemberment insurance plan through Guardian provides: A layer of financial protection in the event of a serious injury or death as a result of an accident.

About Your Benefits:

Employee benefit is $10,000 to $300,000 in $10,000 increments.

Example Benefit Amounts

	$10,000	$20,000	$40,000	$50,000	$70,000	$90,000	$100,000	$120,000	$150,000	$170,000	$200,000
Monthly Premiums* (Estimated premium deduction)											
Employee	$0.48	$0.96	$1.92	$2.40	$3.36	$4.32	$4.80	$5.76	$7.20	$8.16	$9.60
Family	$0.76	$1.52	$3.04	$3.80	$5.32	$6.84	$7.60	$9.12	$11.40	$12.92	$15.20

Additional Benefit Amounts Available	$220,000	$250,000	$270,000	$300,000
Monthly Premiums* (Estimated premium deduction)				
Employee	$10.56	$12.00	$12.96	$14.40
Family	$16.72	$19.00	$20.52	$22.80

Benefit Payments for family coverage vary based on the family structure at the time of claim.

Spouse benefit is 50% of employee amount
Child (ren) benefit is 10% of employee amount

Benefit Reductions—Please be aware that your Benefit Amount may decrease as shown below:

Applicable to Your Supplemental Coverage	35 % at Age 70
	55 % at Age 75
	70 % at Age 80
	80 % at Age 85

Enhanced AD&D Features Include: Child Education Benefit, Education & Retraining Benefit, Seatbelt & Airbag Benefit, Day Care Expense, Repatriation, and Common Carrier.

Manage Your Benefits:

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

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATION AND EXCLUSIONS FOR AD&D:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al . We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specific period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specific period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

HEALTH PLANS NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

OTHER USES AND DISCLOSURES OF PHI

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

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

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

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

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

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

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

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

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

Effective Date: 01.2019
Reviewed: 10/19/2022

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Division of Employee Benefits at (330)643-5551.

.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
County of Summit	34-6002767
5. Employer address	**6. Employer phone number**
1180 S. Main Street	(330)643-2500

7. City	8. State	9. ZIP code
Akron	Ohio	44301

10. Who can we contact about employee health coverage at this job?	
The Division of Employee Benefits	
11. Phone number (if different from above)	**12. Email address**
(330) 643-5551	mcarr@summitoh.net

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All full-time employees working 35 hours or more per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses and dependent children up to age 26.

☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

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

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

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

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

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