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 the Division of Employee Benefits at (330) 643-5551 or Insurance@summitoh.net.

2025 Benefit Premiums – Veterans Service Commission

The charts below summarize County and Employee benefit premiums for coverage in 2025.

Medical & Prescription Coverage

Medical Mutual PPO Advantage

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$41.15	$370.31
Family	$110.81	$997.28

Medical Mutual MedFlex Plan

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$16.03	$304.62
Family	$43.18	$820.41

Medical Mutual Maximum Value Plan (HSA)

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$15.77	$247.08
Family	$42.47	$665.41

SummaCare

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$16.03	$304.62
Family	$43.18	$820.41

Dental Coverage

MetLife Dental PPO & MAC Plans

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$0.00	$12.90
Family	$0.00	$38.22

Vision Coverage

Davis Vision

	Employee Bi-Weekly	Employer Bi-Weekly
Single	$0.00	$1.98
Family	$0.00	$5.46

Monthly Cash Incentive – County employees will receive a $50 monthly cash incentive 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 a dependent to each other and elect County coverage under one employee are not eligible for the monthly cash incentive. You will still be eligible for the other employee benefit programs. Employees are subject to the applicable terms of their collective bargaining agreement.

MEDICAL
PLAN COMPARISON

	MEDFLEX PLAN	ADVANTAGE PLAN		MAXIMUM VALUE PLAN (HSA)		SummaCare	
	In-Network Only	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible							
Single	$500	$1,200	$2,400	$3,300	$6,600	$500	$6,400
Family	$1,000	$2,400	$4,800	$6,600	$13,200	$1,000	$12,800
Co-Insurance (after deductible)	10% | 90%	20% | 80%	40% | 60%	100%	60%	10% | 90%	40% | 60%
Single	$2,000	$3,000	$6,000	$0	$11,000	$1,500	$17,400
Family	$4,000	$6,000	$12,000	$0	$22,000	$3,000	$34,800
Maximum Out of Pocket (Includes deductible, coinsurance, and all copays)							
Single	$7,350	$7,350	$22,050	$3,300	$17,600	$7,350	$23,800
Family	$14,700	$14,700	$44,100	$6,600	$35,200	$14,700	$47,600
Office Visit: PCP | Specialist	$20 | $40	$25 | $50	40% after deductible	0% after deductible	40% after deductible	$10 | $20	60% after deductible
Preventive Office Visit	0%	0%	40% after deductible	0%	40% after deductible	0%	60% after deductible
Emergency Room (true emergency, waived if admitted)	$150	$250	$250	0% after deductible	0% after deductible	$150	$150
Urgent Care: PCP | Specialist	$40	$50	40% after deductible	0% after deductible	40% after deductible	$30	Not Covered
Diagnostic Services (X-ray & diagnostic medical tests)	10% after deductible	20% after deductible	40% after deductible	0% after deductible	40% after deductible	10% after deductible	60% after deductible
Diagnostic Lab (Free standing facilities)	$20	$25	40% after deductible	0% after deductible	40% after deductible	$10	60% after deductible
Diagnostic Lab (Institutional)	10% after deductible	20% after deductible	40% after deductible	0% after deductible	40% after deductible	10% after deductible	60% after deductible

Prescription Drugs				
Retail Pharmacy	$10/$25/$50 (Brand Copay + difference of cost if generic available)	0% after deductible	$10/$25/$50 (Brand Copay + difference of cost if generic available)	Not Covered
Mail Order | 90 Day Retail	$20/$50/$100 (Brand Copay + difference of cost if generic available)	0% after deductible	$20/$50/$100 (Brand Copay + difference of cost if generic available)	Not Covered

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Network: PDP Plus

	Plan option 1 MAC plan		Plan option 2 PPO Plan	
	In-Network[1] % of Negotiated Fee[2]	**Out-of-Network[1]** % of Maximum Allowable Charge	**In-Network[1]** % of Negotiated Fee[2]	**Out-of-Network[1]** 90% of R&C Fee**
Coverage Type				
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	100%	100%	80%	80%
Type C: Major Restorative (bridges, dentures)	60%	60%	50%	50%
Type D: Orthodontia	50%	50%	50%	50%
Deductible†				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit				
Per Person	$1,750	$1,750	$1,750	$1,750
Orthodontia Lifetime Maximum				
Per Person	$1,500	$1,500	$1,500	$1,500

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2]Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
† Applies only to Type B & C Services.

List of Primary Covered Services & Limitations*

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category,but is not a complete description of the Plan.

Plan Type	Plan Option 1: MAC PLAN How Many/How Often	Plan Option PPO PLAN How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per calendar year	Two per calendar year
Oral Examinations	Two exams per calendar year	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar	One fluoride treatment per calendar year

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

X-rays	• Full mouth X-rays; one per 36 months • Bitewings X-rays; two sets per calendar year for children & adults	• Full mouth X-rays; one per 36 months • Bitewing X-rays; two sets per calendar year for children & adults
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday	Space maintainers for dependent children up to his/her 14th birthday
Sealants	One application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday	One application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday
Type B — Basic Restorative		
Fillings		
Simple Extractions		
Crown, Denture and Bridge Repairs/ Recementations	1 in 12 months	1 in 12 months
Oral Surgery		
Endodontics	Root canal treatment limited to once per tooth per lifetime	Root canal treatment limited to once per tooth per lifetime
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year
Type C — Major Restorative		
Implants	Replacement once every 84 months	Replacement once every 84 months
Implant services	1 per tooth position in 84 months	1 per tooth position in 84 months
Implant Repairs	1 per tooth in 24 Months	1 per tooth in 24 Months
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Crowns, Inlays and Onlays	Replacement once every 60 months	Replacement once every 60 months
Type D — Orthodontia		
	• Your children, up to age 19, are covered while Dental insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary. • Orthodontic benefits end at cancellation of coverage	• Your children, up to age 19, are covered while Dental insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary. • Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Questions & Answers

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at or call to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit or request one by calling

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Q. Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.

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.

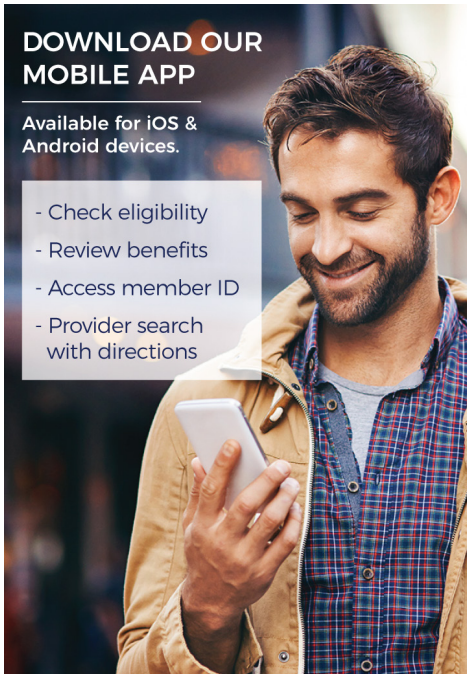
Find a network provider...

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

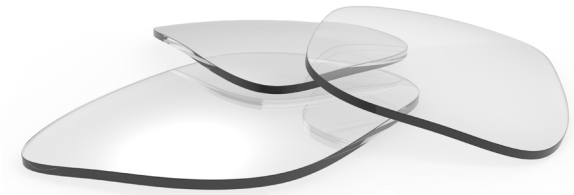
Lens options

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®

COUNTY OF SUMMIT
CLASS 3 - ALL ACTIVE FULL TIME SUMMIT COUNTY EMPLOYEES, LOCAL 1229 CLERK OF COURT, FISCAL, SARCOG, AND LOCAL 2696 EXCLUDING SALARIED EMPLOYEES OF PUBLIC HEALTH DIVISION AND EMPLOYEES WHO ARE SUBJECT TO A COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 3885 AND ALL OTHER LOCAL 1229
Group Number: 00576937

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Your coverage options

Life insurance	Protecting your family's financial future

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Guardian®

Watch our video
How life insurance protects families and covers critical costs.

Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.

Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **$9,000**

Average mortgage debt: **$202,000**

Average cost of college: **$17,000 - $44,000**

Average household credit card debt: **$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

ALL ACTIVE FULL TIME SUMMIT COUNTY EMPLOYEES, LOCAL 1229 CLERK OF COURT, FISCAL, SARCOG, AND LOCAL 2696 EXCLUDING SALARIED EMPLOYEES OF PUBLIC HEALTH DIVISION AND EMPLOYEES WHO ARE SUBJECT TO A COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 3885 AND ALL OTHER LOCAL 1229

2023-158796 (07/25)

Kit created 02/07/2025
Group number: 00576937

Guardian®

Your life coverage

	BASIC LIFE
Employee Benefit	Your employer provides $50,000 Basic Term Life coverage for all full time employees.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.
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.	Underwriting may be required, depending on amount and/or age
Premiums	Covered by your company if you meet eligibility requirements
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.	For employees disabled prior to age 60, with premiums waived until normal retirement age, if conditions are met

Subject to coverage limits

COUNTY OF SUMMIT

ALL ACTIVE FULL TIME SUMMIT COUNTY EMPLOYEES, LOCAL 1229 CLERK OF COURT, FISCAL, SARCOG, AND LOCAL 2696 EXCLUDING SALARIED EMPLOYEES OF PUBLIC HEALTH DIVISION AND EMPLOYEES WHO ARE SUBJECT TO A COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 3885 AND ALL OTHER LOCAL 1229

Kit created 02/07/2025

Group number: 00576937

Your life coverage

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D 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.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

For AD&D: 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 er 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.

GP-1-R-LB-90

COUNTY OF SUMMIT

ALL ACTIVE FULL TIME SUMMIT COUNTY EMPLOYEES, LOCAL 1229 CLERK OF COURT, FISCAL, SARCOG, AND LOCAL 2696 EXCLUDING SALARIED EMPLOYEES OF PUBLIC HEALTH DIVISION AND EMPLOYEES WHO ARE SUBJECT TO A COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 3885 AND ALL OTHER LOCAL 1229

Kit created 02/07/2025
Group number: 00576937

Guardian®

Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

COUNTY OF SUMMIT
ALL ACTIVE FULL TIME SUMMIT COUNTY EMPLOYEES, LOCAL 1229 CLERK OF COURT, FISCAL, SARCOG, AND LOCAL 2696 EXCLUDING SALARIED EMPLOYEES OF PUBLIC HEALTH DIVISION AND EMPLOYEES WHO ARE SUBJECT TO A COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 3885 AND ALL OTHER LOCAL 1229

Kit created 02/07/2025
Group number: 00576937

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact
HRD - Division of Employee Benefits, (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.

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)643-5551

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

10. Who can we contact about employee health coverage at this job?	
HRD - Division of Employee Benefits	
11. Phone number (if different from above)	12. Email address Insurance@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:

    Full-time employees working between 30-40 hours or more per week dependent upon their agency policy
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouses and child dependents 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)

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: 08/19/2024

ILENE SHAPIRO
COUNTY EXECUTIVE

Department of Law, Insurance and Risk Management

To: Employees enrolled in the County of Summit Employee Benefit Program

From: Brian K. Harnak, Privacy Office, Department of Law and Risk Management

Subject: Federal Standards: County of Summit's Privacy Practices and the Health Insurance Portability and Accountability Act (HIPAA).

Date: August 19, 2024

Medical and other health information is private and should be protected. The Privacy Rule, a Federal law, gives you rights that cover your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule, a Federal law that protects health information in electronic form, requires entities covered by HIPAA to ensure that electronic protected health information is secure. The County of Summit Employee Benefit plan is a self-insured plan, therefore the County is subject to these rules as a covered entity.

As part of the HIPAA regulations, County of Summit is required to advise employees of the County's privacy practices with regard to your protected health information. Protected health information (PHI) is defined as information about you, which is maintained by the County of Summit to carry out certain health care operations such as eligibility, enrollment, collection of premiums and payment of claims on your behalf.

Any health information received by the County of Summit Department of Human Resources, Division of Employee Benefits staff is, and shall continue to be, handled in a confidential manner. The County of Summit has implemented a number of security measures to help prevent unauthorized access to such information.

You are encouraged to carefully review the Notice of Privacy Practices document located at HREB.summitoh.net, under the HELP link. If you have questions after reviewing this document, please contact Brian K. Harnak, (330) 643-2196 or bharnak@summitoh.net. This notice does not affect your eligibility or benefits. Neither this notice nor any of the other documentation requires any response from you.