Geauga County Commissioners

Section 125

SUMMARY PLAN DESCRIPTION

Restatement effective October 1, 2015

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Geauga County Commissioners
Section 125 Plan With Premium Payment Component

Article I
INTRODUCTION

Geauga County Commissioners, (the "Employer") sponsors the Geauga County Commissioners Section 125 Plan (the "Cafeteria Plan") that allows Eligible Employees to pay for the medical insurance benefit with pre-tax dollars. Alternatively, Eligible Employees may choose to pay for the Employer's group medical insurance benefits with after-tax contributions on a payroll-reduction basis.

This Summary Plan Description (SPD) describes the basic features of the Section 125 Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Plan and is not meant to interpret or change the provisions of your Plan. A copy of your Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the Plan document and this Summary, the Plan Document shall govern.

Article II
PARTICIPATION IN YOUR PLAN

How can I participate in the Cafeteria Plan?

Once an Employee has met the Plan's eligibility requirements, and provided that the election procedures outlined under **'How do I become a Participant and when is my Entry Date?'** section are followed, the Eligible Employee may participate in the Plan.

What are the Eligibility Requirements to participate in the Plan?

Employees who are eligible to participate in the Employer's group medical insurance may participate in the Plan once they meet the eligibility requirements and provided that the election procedures outlined under '**How do I become a Participant?**' section are followed. Eligibility for the Premium Insurance Benefits is also subject to the additional eligibility requirements, if any, specified in the Medical Insurance Plan.

Are there any Employees who are not eligible to participate in the Plan?

The following Employees are excluded from participating in the Plan: self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

How do I become a Participant and when is my Entry Date?

After you satisfy the eligibility requirements described under **'What are the Eligibility Requirements to participate in the Cafeteria Plan?',** you will be automatically enrolled in the plan on the date you become enrolled in one of more of the employer’s group health plans. You may also elect not to pay premiums on a pre-tax basis by signing a waiver of election form and submitting it to your employer.

If an Employee is eligible for Premium Insurance Benefits and has made an effective election to waive pretax payment for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as explained under **'Can I change my elections under the Cafeteria Plan during the Plan Year?'),** a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

Employees who actually participate in the Cafeteria Plan are called "Participants." An Employee continues to participate in the Cafeteria Plan until: (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

However, for purposes of pre-taxing COBRA coverage for Premium Insurance Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See **'What is Continuation Coverage and how does it work?'**, and **'What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?'** for information about how termination of participation affects your Benefits.

What is the "Open Enrollment Period" and the "Plan Year"?

The Open Enrollment Period is the period during which you have an opportunity to participate under the Plan by signing and returning an individual Election Form or waiver form.

You will be notified of the timing and duration of the Open Enrollment Period prior to the beginning of the new Plan Year. The Plan Administrator will inform all Participants of the applicable dates for each annual enrollment period.

What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan for the Premium insurance benefits.

The Premium Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

See '**What is Continuation Coverage and how does it work?**' and the booklets for the Medical Insurance Plan for information on your right to continued or converted group health coverage after termination of your employment.

For purposes of pre-taxing COBRA coverage for Premium Insurance Benefits, certain Employees may be able to continue eligibility in the Plan for certain periods. See '**What is Continuation Coverage and how does it work?**'

If you are rehired within 30 days or less during the same Plan Year and are eligible for the Plan, then your prior elections will be reinstated.

If you are rehired more than 30 days after you terminated employment, and are eligible for the Plan, you will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, you may rejoin the Plan without having to complete the waiting period before again becoming eligible to participate in the Plan again.

What is "Continuation Coverage" and how does it work?

To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the medical insurance plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), may be given the opportunity to continue on a self- pay basis the same coverage that he or she had under the medical insurance plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for medical insurance benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either: (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for medical insurance benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the applicable Period of Coverage. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

USERRA
Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

How does a leave of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence
If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your the Premium insurance benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Premium Insurance Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Premium Insurance Benefits, then you may pay your share of the contributions in one of the following ways:

* with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
* Pre-pay with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
* Pay-as-you-go with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or

If your Employer requires all Participants to continue Premium Insurance Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Premium Insurance Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as life insurance, etc.) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid:

* with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
* with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or
* under another arrangement agreed upon between the Participant and the Plan

Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see **'When Can I Change Elections Under the Plan During the Plan Year?'**).

Article III
PAYING FOR YOUR BENEFITS UNDER YOUR PLAN

How do employees pay for benefits on a pre-tax basis?

An Employee's election to pay for benefits on a pre-tax is automatic. You may also elect to pay for benefits on an after-tax basis by signing an election waiver form under this Plan. When you pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Will I pay any administrative costs under the Plan?
No. The cost of the plan includes administrative expenses and is paid entirely by the Employer.

Can I change my elections under the Plan during the Plan Year?
You generally cannot change your election to participate in the Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various "Change in Election Events" that are described under '**When Can I Change Elections Under the Cafeteria Plan?**'. The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

When can I change elections under the cafeteria plan during the Plan Year?
Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various 'Change in Election Events' headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined under '**How do leaves of absence (such as under FMLA) affect my benefits?**'); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence.

If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence
(Applies to Medical Insurance Benefits)
You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described under **'How do leaves of absence (such as under FMLA) affect my benefits?'**

2. Change in Status.
(Applies to Medical Insurance Benefits) If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

* a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
* a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
* any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
* an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, or a similar circumstance); or
* a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status-Other Requirements.
(Applies to Medical Insurance Benefits)
If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the

event affects coverage eligibility.

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

* *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits (the Medical Insurance Plan), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See '**What is "Continuation Coverage" and how does it work?**'.

* *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

4. Special Enrollment Rights. *(Applies to Medical Insurance Benefits)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Cafeteria Plan to correspond with

the special enrollment right.

5. Certain Judgments, Decrees, and Orders. *(Applies to Medical Insurance Benefits)* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to Medical Insurance Benefits)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits, as applicable).

7. Change in Cost. *(Applies to Medical Insurance Benefits)* If the cost charged to you for your Medical Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits.

8. Change in Coverage. *(Applies to Medical Insurance Benefits)* You may also change your election if one of the following events occurs:

Significant Curtailment of Coverage. If your Medical Insurance Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage.)

Addition or Significant Improvement of Cafeteria Plan Option. If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

Loss of Other Group Health Coverage. You may prospectively change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP); a medical care program of certain Indian Tribal programs or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

An election change on account of a HIPAA special enrollment attributable to an employee or dependent becoming eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 60 days).

Change in Election Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

9. **Revocation of coverage under a group health plan contingent on enrollment in another qualified health plan *(Applies to Medical Insurance Benefits only)***

An employee to prospectively revoke an election of coverage under a group health plan that is not a health FSA and that provides minimum essential coverage (as defined in § 5000A(f)(1)) provided the following conditions are met:

(a) Conditions for revocation due to reduction in hours of service

i. The employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee’s status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and
ii. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

A cafeteria plan may rely on the reasonable representation of an employee who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the employee and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(b) Conditions for revocation due to enrollment in a Qualified Health Plan

i. The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and

Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

ii. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

A cafeteria plan may rely on the reasonable representation of an employee who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the employee and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Article IV
WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

What benefits may be elected under the Plan?
The Cafeteria Plan includes the following benefit plans:

***Premium Payment Component (currently including Premium Insurance Benefits)* -** permits an Employee to pay for his or her share of contributions for the Medical Insurance Plan with pre-tax dollars. "Medical Insurance Plan" means the major medical plan that your Employer maintains for Employees, their Spouses, and Dependents, providing major medical type benefits through a group insurance policy.

Here, these benefits include Health and Dental Benefit options. Benefits provided under the Medical Insurance Plan are called "Premium Insurance Benefits." Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called "Premium Payment Benefits";

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Cash Benefit - Each Employee who waives coverage under the Employer's group health plan may receive additional taxable compensation, in an amount to be determined by the Employer annually, prior to the beginning of the open enrollment period for group health benefits.

Article V
HOW BENEFITS ARE TAXED

What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Premium Insurance Benefits under the Cafeteria Plan. Suppose that you are married and have one child and that your share of the required contributions for Premium Insurance Benefits for family coverage is an annual total of $6,400. Suppose also that your gross pay is $75,000 and your Spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the example below, if you elect to salary-reduce $6,400 to pay for the Premium Insurance contributions, then your annual take-home pay would be $56,732. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only $55,012. This is because by participating in the Cafeteria Plan for Premium Insurance contributions, you will be considered for tax purposes to have received $68,600 in gross pay, so you save $1,720 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

Caution: The amount of the contributions used in this example is not meant to reflect your actual contributions-the actual contribution amounts will be determined by you.

EXAMPLE ONLY	Cafeteria Plan*	No Cafeteria Plan
1. Adjusted Gross Income	$75,000	$75,000
2. Salary Reductions for Premiums	($6,400)	$0
3. W-2 Gross Wages	$68,600	$75,000
4. Standard Deduction	($10,000)	($10,000)
5. Exemptions	($9,600)	($9,600)
6. Taxable Income (line 3 minus lines 4 & 5)	$49,000	$55,400
7. W-2 Gross Wages	$68,600	$75,000
8. Federal Income Tax (line 6 @ tax schedule)	($6,620)	($7,850)
9. FICA Tax (7.65% of line 3)	($5,248)	($5,738)
10. After-Tax Premium Payments	$0	($6,400)
11. Pay After Taxes and Premium Payments (line 7 minus lines 8, 9 & 10)	$56,732	$55,012

How will participating in the Plan affect my Social Security and other benefits?
Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Article VI
FUNDING

Funding This Plan
All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

How long will the Cafeteria Plan remain in effect?
Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

Article VII

GENERAL INFORMATION

What other general information should I know?
This question contains certain general information that you may need to know about the Plan. **Note:** This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan.

General Plan Information

* Name: Geauga County Commissioners Section 125 Cafeteria Plan
* Plan Number: 501
* Effective Date: October 1, 2015. The Plan was originally effective January 1, 1997
* Plan Year: January 1st to December 31st.
  Your Plan's records are maintained on this 12- month period of time.
* Type of Plan: Fringe Benefit Premium-Only Plan (POP)
* Your plan shall be governed by the Laws of the State of Ohio

Employer/Plan Sponsor Information

Geauga County Commissioners
470 Center Street, Building #4
Chardon, OH 44024

(440) 279-1600

Federal Employer Tax Identification Number (EIN): 34-6001208

Plan Administrator Information
Name, address, and business telephone number:

Geauga County Commissioners
470 Center Street, Building #4
Chardon, OH 44024

(440) 279-1600

The Plan Administrator appoints the Benefits Administrator to keep the records for the Plan and to be responsible for the administration of the Plan.

Funding and Type of Plan Administration
All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy.

Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment

Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Agent for Service of Legal Process
The name and address of the Plan's agent for service of legal process is:

Geauga County Commissioners
470 Center Street, Building #4
Chardon, OH 44024

(440) 279-1600

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA (Genetic Information Non-Discrimination Act) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)
Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

Medical Insurance Plan Documents and Information
This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan.