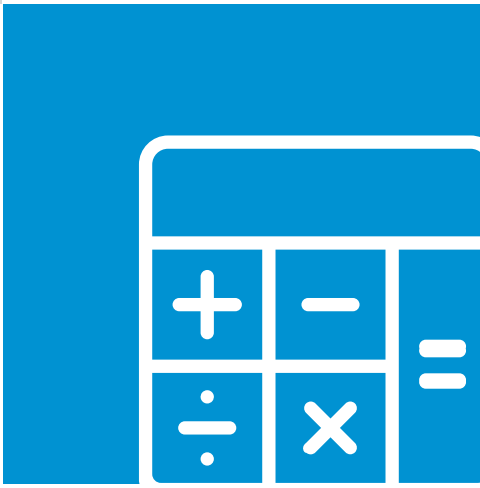
Northeast Ohio
Regional Sewer District





2025

# Benefits Guide

## Good Neighbor Ambassador

Enrolling in Your Benefits

Log in to UKG

Begin the benefits enrollment process

Elect the benefits you want

Save or submit your elections

Print a copy of your elections for your records

# Your NEORSD Benefits

We understand the important role that benefits play in the lives of you and your family. As a new hire, and then annually during open enrollment, you have an opportunity to make changes to your benefits package to ensure you and your family have the right coverage.

This benefits guide can help familiarize you with NEORSD's benefit options. It also provides useful tips, tools and resources to help you think through your options and make wise decisions. As you prepare to enroll:

- Consider your benefit coverage needs for the upcoming year.
- Consider other available coverage.
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. In addition, you may need to provide legal documentation verifying their eligibility — such as a marriage license or birth certificate.

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

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# Cost of Your Benefits

NEORSD pays the full cost of many of your benefits and you share the cost for others. You pay the full cost for any voluntary benefits.

| Benefit | Tax Treatment | Who Pays |
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| **Medical and Pharmacy Coverage** | Pretax | NEORSD & You |
| **Dental Coverage** | Pretax | NEORSD & You |
| **Vision Coverage** | Pretax | NEORSD & You |
| **Hearing Coverage** | Pretax | NEORSD & You |
| **Employee Assistance Program (EAP)** | Pretax | NEORSD |
| **457(b) Retirement Savings Plan** | Pretax | You |
| **Roth IRA** | After-tax | You |

# Benefit Basics

As a part-time employee, you have the option to elect or decline health care benefits for yourself and your eligible dependents.

Once enrolled, benefit elections will become effective retroactive to your first day of employment with NEORSD. The following dependents may be enrolled in any coverage option in which you are enrolled:

- Your legal spouse
- Your children up to age 26

In order to elect health care benefits for yourself and your eligible dependents, you must enroll in benefits within 30 days of your first day of employment via UKG.

Your premiums for NEORSD health care benefits are deducted from your paycheck on a pretax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

## Changes to your benefits

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualifying life event such as:

- Loss or gain of other coverage for you or your dependent under another employer's plan
- Change in legal status such as marriage, divorce or legal separation
- Change in the number of dependents, including by birth, death and adoption
- Adult dependent reaches age 26
- Entitlement or loss of entitlement to Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)
- Qualification by the Plan Administrator of a child support order for medical coverage

**You have 30 days from the date of your qualified life event to make changes to your coverage.** You must provide supporting documentation as proof of the event (e.g. birth certificate, marriage license or adoption papers). If you do not submit the qualifying life event in UKG within 30 days of the event, you will have to wait until the next open enrollment period to make changes (unless you experience another qualified life event).

### Questions?

If you have any questions, please reach out to Human Resources:

- Email HRDirect@neorsd.org
- Call 216-391-6444
- Dial 6444 from any District phone

# Medical and Pharmacy Plan Overview

NEORSD offers the SuperMed PPO* Plan, administered by Medical Mutual of Ohio (MMOH). You and your family members who are covered on the Medical Plan are automatically enrolled in the Pharmacy Plan administered by Express Scripts.

## Understanding how your plan works

### 1. Your deductible

- You pay out-of-pocket for most medical and pharmacy expenses, except those with a copay, until you reach the deductible.

### 2. Your coverage

- Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses. The plan will pay a percentage of each eligible expense and you will pay the rest.

### 3. Your out-of-pocket maximum

- When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

## Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- ***Preferred Provider Organization (PPO):** A network of physicians, hospitals and other providers who have agreed to accept pre-negotiated, discounted rates for medical services.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Pharmacy coverage:** Medications are placed in tiers based on drug cost, safety and effectiveness. These tiers also affect your coverage.
  - **Generic** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered “preferred” because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name. This type of drug is “not preferred” and is usually more expensive than alternative generic and brand preferred drugs.

To obtain information about participating network providers in our area, visit the MMOH My Health Plan website at https://member.medmutual.com.

# Medical and Pharmacy Coverage

| Medical Plan Provisions | SuperMed PPO – $500 Plan | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Annual Deductible** (Individual/Family) | $500/$1,000 | |
| **Out-of-Pocket Maximum** (Includes Deductible) | $2,000/$4,000 | $3,500/$7,000 |
| **Preventive Care** | Covered at 100% | 70%* |
| **Primary Care Provider Office Visit** | $20 copay | 70%* |
| **Specialist Office Visit** | $20 copay | 70%* |
| **Inpatient Hospital Services** | 80% | 70%* |
| **Outpatient Hospital Services** | 80% | 70%* |
| **Urgent Care** | $20 copay | 70%* |
| **Emergency Room Care** | $100 copay<br>$150 copay (non-emergency visits) | 70%* |
| **Pharmacy Provisions** | **In-Network** | **Out-of-Network** |
| **Annual Rx Deductible** (Individual/Family) | $0/$0 | |
| **Pharmacy Out-of-Pocket Maximum** (Individual/Family) | $5,600/$11,200 | Not applicable |
| **Retail Pharmacy (up to a 30-day supply)** | | |
| **Generic** | $20 copay | Not covered |
| **Brand Preferred** | $40 copay | Not covered |
| **Brand Non-Preferred** | $80 copay | Not covered |
| **Mail Order Pharmacy (90-day supply)** | | |
| **Generic** | $20 copay | Not covered |
| **Brand Preferred** | $40 copay | Not covered |
| **Brand Non-Preferred** | $80 copay | Not covered |

*After deductible is met

# Telemedicine

When you are covered by NEORSD's Medical Insurance, you and your covered dependents have access to the Cleveland Clinic Express Care® Online. This service provides 24/7 access to U.S. board-certified doctors from anywhere via your smartphone, tablet, or computer.

Each virtual visit costs the same as your Office Visit Copay **($20)**.

This is a fast and convenient alternative to waiting days for an appointment or spending hours sitting in a doctor's office, urgent care clinic, or emergency room for a non-urgent condition.

**Register in advance to save time later when you need to use this service.**

- Download the free App or Learn More: Clevelandclinic.org/eco

**Note:** If you are experiencing a medical emergency, call 9-1-1 or go to the nearest emergency room.

# Dental Coverage

It's important to have regular dental exams and cleanings so problems are detected before they become painful — and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health.

NEORSD offers a Dental PPO Plan administered by Delta Dental. The chart below is a high-level summary of your benefits. Please refer to Delta Dental's Summary of Benefits and Coverage (SBC) for additional details and exclusions. You may be responsible for non-covered charges and billed charges for all services and supplies after your benefit maximum has been reached.

| Plan Provisions | Delta Dental PPO Plan | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Annual Deductible** (Individual/Family) | $25 per individual | |
| **Calendar Year Maximum** | $1,500 per individual | |
| **Orthodontia Lifetime Maximum** | $2,000 | |
| **Routine and Preventive Services** (e.g., X-rays, cleanings, fluoride treatments) | Covered at 100% | |
| **Essential Services** (e.g., fillings, periodontics, oral surgery) | 80%* | |
| **Complex Services** (e.g., dentures, crowns, bridges) | 80%* | |
| **Orthodontia** | 60%* for children up to age 26 | |

*After deductible is met

### Using in-network dental providers

While you have the option of choosing any provider, you will save money when you use in-network dentists. When using an out-of-network dental provider, you will pay more because the provider has not agreed to charge you a negotiated rate. For more detailed information, please see the Delta Dental Stay In Network and Save flyer. To find an in-network provider, please visit www.deltadentaloh.com/findadentist.

# Vision Coverage

NEORSD offers vision coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. The vision plan is administered by Medical Mutual of Ohio (MMOH) utilizing the EyeMed provider network and provides coverage when you seek care from designated vision providers.

| Plan Provisions | MMOH Vision Plan | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Exam** | $10 copay | Up to $30 |
| **Frames** | $0 copay; $150 allowance, 20% off balance over $150 | Up to $75 |
| **Lenses** | | |
| ▪ Single Vision Lenses | $25 copay | Up to $30 |
| ▪ Bifocal Lenses | $25 copay | Up to $45 |
| ▪ Trifocal Lenses | $25 copay | Up to $60 |
| ▪ Lenticular | $25 copay | Up to $60 |
| ▪ Progressive Lenses | $90 copay | Up to $45 |
| **Contact Lenses** (Instead of Lenses and Frames) | | |
| ▪ Cosmetic | $0 copay, then $150 allowance | Up to $120 |
| ▪ Medically Necessary | Covered at 100% | Up to $210 |
| **Frequency** | | |
| ▪ Exam | Once every 12 months | Once every 12 months |
| ▪ Lenses | Once every 12 months | Once every 12 months |
| ▪ Frames | Once every 24 months | Once every 24 months |
| ▪ Contact Lenses | Once every 12 months | Once every 12 months |

*Maximum reimbursements

Find vision providers by visiting www.medmutual.com and searching the SuperMed PPO network within the group coverage options.

# Hearing Coverage

NEORSD provides you and your family hearing benefits. Below is a schedule of the services covered by the plan administered by Medical Mutual of Ohio (MMOH).

You may seek services from any hearing provider; however, you will want to request an estimate of the charges that you may be responsible for that exceed the policy coverage limits.

| Plan Provisions | MMOH Hearing Plan<br>In-Network Only |
|---|---|
| **Audiometric Exam** | Covered at 100%, up to $40 |
| **Hearing Aid Evaluation Test** | Covered at 100% |
| **Hearing Aids** | Covered at 100% |
| **Conformity Evaluation*** | Covered at 100% |
| **Frequency**<br>▪ Audiometric Exam<br>▪ Hearing Aid Evaluation Test<br>▪ Hearing Aids (Two Total)<br>▪ Conformity Evaluation | <br>Once every 36 months<br>Twice every 36 months<br>Once every 36 months<br>Twice every 36 months |

*Consists of an evaluation of the performance of the prescribed hearing aid against the prescription

Please refer to MMOH's Summary of Benefits and Coverage (SBC) for more details as well as exclusions (i.e., coverage does not include coverage for replacement parts for and repairs of hearing aids).

# Payroll Contributions

Non-Union Employees monthly payroll contributions for medical, dental, hearing and vision benefits are shown here.

| Medical Coverage | SuperMed PPO – $500 Plan |
|---|---|
| **Employee Only** | $136.39 |
| **Employee + 1** | $272.46 |
| **Employee + Family** | $373.21 |

| Dental Coverage | Delta Dental PPO Plan |
|---|---|
| **Employee Only** | $5.34 |
| **Employee + 1** | $10.67 |
| **Employee + Family** | $15.35 |

| Vision and Hearing Coverage | |
|---|---|
| **Employee Only** | $0.75 |
| **Employee + 1** | $1.47 |
| **Family** | $1.85 |

**Note:** Payroll contributions apply to all Full-Time, Part-Time, Interns, and Temporary employees.

# Employee Assistance Program

## Employee Assistance Program

Because personal issues can affect every aspect of your life, NEORSD provides you and your family with an Employee Assistance Program through ESI EAP at **no cost** to you.

ESI is a confidential employer-sponsored program designed to identify and assist employees and eligible dependents in resolving personal problems that may be adversely affecting daily-life as well as providing preventive wellness tools. You and members of your household are eligible to receive 6 free counseling sessions per person, per issue.

EAP counselors are available to assist you with concerns such as:

- Marital and relationship issues
- Alcohol and drug abuse
- Stress management
- Family/parenting problems
- Work relationships
- Legal and financial problems
- Assistance with referrals and self-help resources for important services such as child care, education, and adoption.

Confidential assistance is available by calling 800-252-4555 or visiting www.theeap.com.

# Other NEORSD Provided Benefits

## Paid Time Off

Coverage is automatic for employees beginning the first day of part-time employment and is prorated on the first year of employment.

Time off is granted and paid according to eligibility schedules outlined in the applicable policies.

Refer to the Employee Handbook for more details.

## Prior Service Credit

NEORSD has a service credit policy for employees previously employed in Ohio by a County, Municipal or State government agency. This policy allows credit to be transferred for use in their current position. Contact HRDirect for the **Prior Service Credit Form**.

Time **excluded** from prior service is as follows:

- Federal or Military service time
- Student employment
- Part-time employment
- Unpaid leave time except Military leave
- Temporary or Seasonal employment

## Employee Discounts

As an employee of NEORSD, you can receive 20% to 60% off on movies, hotels, theme parks, concerts, sporting events, and more.

**Sign up today in less than 60 seconds!**

- Go to www.ticketsatwork.com
- Click “Become a Member”
- Create an account using our company code: **NEORSD17**

# Retirement Savings Plans

Whether retirement is way down the road or just around the corner, it's important to have savings goals and specific investment objectives.

## Mandatory Retirement Savings Plans

As a public employee of Ohio, you contribute to the Ohio Public Employee Retirement System (OPERS) rather than Social Security. Both employee and employer contribution amounts are statutorily determined and codified in the Ohio Revised Code and are subject to change. They cannot be increased or decreased by the individual employee. Current contributions are as follows:

**10%** your contribution
\+ **14%** your employer's contribution
**24%** of your salary being invested for your future

## Plan Selection

New members have 180 days from date of hire to select a retirement plan. More information can be found at: https://www.opers.org/members/Plan-select/index.shtml. If an election is not made, your account will default to the Traditional Pension Plan.

Traditional Pension Plan is a defined benefit plan that provides fixed, monthly lifetime retirement benefits. This plan offers security because your retirement income is based on a formula that includes your final average salary and years of service and is not subject to investment gains and losses. OPERS investment professionals manage the investment of both your member and employer contributions.

Your benefit is determined by a formula that rewards you for working longer – the more years you work, the bigger your monthly payment.

Member Directed Plan is a defined contribution plan where you direct how your contributions are invested choosing from one (or more) of the OPERS investment options. You bear sole responsibility for the investment risk, similar to the way a 401(k) plan works in the private sector.

Your benefit is based on your final vested account balance at retirement.

You have a number of distribution options when you retire including taking a monthly lifetime annuity, a lump sum refund, or rolling over your balance to another account.

## Voluntary Retirement Savings Plans

The Sewer District offers three investment plans created in accordance with Internal Revenue Code Section 457 (IRC 457). A deferred compensation plan is a voluntary retirement savings plan that allows participants to supplement any existing retirement/pension benefit by saving and investing through payroll contributions. Eligible employees of the Sewer District may elect to participate in the following plans:

- **VOYA** – Traditional 457 Contributions are deducted from employee's pay on a pre-tax basis which reduce gross taxable income in the calendar year contributed and are subject to federal and state taxes when funds are withdrawn.
- **Ohio Deferred Compensation** – Traditional 457 Contributions are deducted from employee's pay on a pre-tax basis which reduce gross taxable income in the calendar year contributed and are subject to federal and state taxes when funds are withdrawn.
- **Ohio Deferred Compensation** – ROTH 457 This option allows employees to make contributions that are not tax deductible, but provide tax-free distributions, after certain conditions are met. Contributions are deducted from employee's pay on an after-tax basis having no impact on calendar year gross taxable income.

Combined contribution limits apply to both pre-tax contributions and Roth Contributions, as defined by the Internal Revenue Service. Deferred compensation is not available to employees until termination, retirement, death, or an unforeseen financial emergency, as defined in IRC 457.

To enroll or get more information, please visit the Ohio Deferred Compensation website at www.ohio457.org. You can enroll in a Roth account online or request paperwork at 877-644-6457. Existing participants will need to log in online and add an account to enroll in Roth 457.

To contact Voya, visit https://www.voya.com/.

**Enroll in Your Employer's Plan**
Voya Retirement Insurance and Annuity Company
Hours: 8 a.m. to 9 p.m. ET Monday through Friday
**888-311-9487**

**Existing Plan Participants and Select Advantage**
Voya Retirement Insurance and Annuity Company
Hours: 8 a.m. to 9 p.m. ET Monday through Friday
**800-584-6001**

# Glossary

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.
- **Calendar Year Maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- **Deductible** – The amount you have to pay for covered services each year before your health plan begins to pay.
- **Elimination Period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Flexible Spending Account (FSA)** – An FSA allows you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.
- **Generic drugs** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail Order Pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, Mail Order Pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Higher deductibles and coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Primary Care Provider (PCP)** – A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Reasonable & Customary Charges (R&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable & Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).

# Contact Information

| Coverage | Carrier | Phone | Website/Email |
|---|---|---|---|
| **Medical and Pharmacy Coverage** | Medical Mutual of Ohio | 800-586-4509 | www.MedMutual.com |
| **Telemedicine** | Cleveland Clinic | 800-223-2273 | Clevelandclinic.org/eco |
| **Dental Coverage** | Delta Dental | 800-524-0149 | www.deltadentaloh.com |
| **Vision Coverage** | Medical Mutual of Ohio | 800-586-4509 | www.MedMutual.com |
| **Hearing Coverage** | Medical Mutual of Ohio | 800-586-4509 | www.MedMutual.com |
| **Employee Assistance Program (EAP)** | ESI EAP | 800-252-4555 | www.theeap.com |
| **Employee Discounts** | TicketsatWork | 407-393-5862 | www.ticketsatwork.com |
| **457(b) Retirement Plan** | Voya Financial | **Enroll in Your Employer's Plan**<br>888-311-9487<br>**Existing Plan Participants and Select Advantage**<br>800-584-6001 | www.voya.com |
| | Ohio Deferred Compensation | 877-644-6457 | www.ohio457.org |
| **Enrollment and Human Resources** | NEORSD | 216-391-6444 | HRDirect@neorsd.org |

# Legal Notices

## HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

**Note:** The 60 days period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 60-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact the Plan Administrator.

## Notice of Availability of the NEORSD Employee Benefit Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

The NEORSD Health and Welfare Benefit Plan (the "Plan") provides health benefits to eligible employees of NEORSD, (the "Company) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information.

To receive a copy of the Plan's Notice of Privacy Practices, contact Janelle Olivier or Karis Rooney (Total Rewards Analysts), who have been designated as the Plan's contacts for all issues regarding the Plan's privacy practices and covered-individuals' privacy rights. You can reach J**anelle Olivier** and **Karis Rooney** at **216-881-6600**.

## Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

# Legal Notices (continued)

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

| | SuperMed PPO – $500 Plan | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Deductible** (Individual/Family) | $500/$1,000 | $500/$1,000 |
| **Coinsurance** | 80% | 70% |

If you would like more information on WHCRA benefits, contact Janelle Olivier and Karis Rooney (Total Rewards Analysts) at 216-881-6600.

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Important Notice from Northeast Ohio Regional Sewer District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Northeast Ohio Regional Sewer District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Northeast Ohio Regional Sewer District has determined that the prescription drug coverage offered by the Northeast Ohio Regional Sewer District employee benefits plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Northeast Ohio Regional Sewer District coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Northeast Ohio Regional Sewer District coverage, be aware that you and your dependents will be able to get this coverage back.

# Legal Notices (continued)

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Northeast Ohio Regional Sewer District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NEORSD changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Date:** October 1, 2022
**Name of Entity/Sender:** Northeast Ohio Regional Sewer District
**Contact—Position/Office:** Human Resources
**Address:** 3900 Euclid Avenue, Cleveland, OH 44115
**Phone Number:** 216-881-6600

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

# Legal Notices (continued)

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program<br>Website: http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

# Legal Notices (continued)

## GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

## INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

## IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

## KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

## KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

## LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

## MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

## MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

## MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

## MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

## MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

## NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

## NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

## NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218

# Legal Notices (continued)

| NEW JERSEY – Medicaid and CHIP | NEW YORK – Medicaid |
|---|---|
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA – Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.]gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

# Legal Notices (continued)

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

## Model COBRA Continuation Coverage General Notice

### Instructions

#### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

# Legal Notices (continued)

## Model General Notice of COBRA Continuation Coverage Rights

**(For use by single-employer group health plans)**

## **Continuation Coverage Rights Under COBRA**

### Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

# Legal Notices (continued)

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

**When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

**How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

# Legal Notices (continued)

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

# Legal Notices (continued)

### If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

### Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### Plan contact information

Northeast Ohio Regional Sewer District Health and Welfare Benefit Plan
Janelle Olivier or Karis Rooney, Total Rewards Analysts
216-881-6600
3900 Euclid Ave.
Cleveland, OH 44115

# Legal Notices (continued)

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

**What is the Health Insurance Marketplace?** The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the immediately following January 1.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?** You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

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.

*As that percentage is adjusted by inflation from time to time.

**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% of such costs.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: HR Direct, 216-391-6444, or HRDirect@neorsd.org.

# Legal Notices (continued)

**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<br>**Northeast Ohio Regional Sewer District (NEORSD)** | 4. Employer Identification Number (EIN)<br>**34-1128332** | |
| 5. Employer address<br>**3900 Euclid Avenue** | 6. Employer phone number<br>**216-881-6600** | |
| 7. City<br>**Cleveland** | 8. State<br>**OH** | 9. ZIP code<br>**44115** |
| 10. Who can we contact about employee health coverage at this job?<br>**HR Direct** | | |
| 11. Phone number (if different from above)<br>**216-391-6444** | 12. Email address<br>**HRDirect@neorsd.org** | |

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 30 hours per week, as well as part-time employees.**

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

**Lawful spouse, natural children, adopted children, children placed for adoption with you, stepchildren, legal ward from birth to the end of the calendar month in which the child attains age 26, or dependent as defined by the IRS tax code, and disabled dependents (conditions apply)**

☐ 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 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.

Northeast Ohio
Regional Sewer District

## About this Guide

This benefit summary provides selected highlights of the Northeast Ohio Regional Sewer District (NEORSD) benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Northeast Ohio Regional Sewer District (NEORSD) reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.