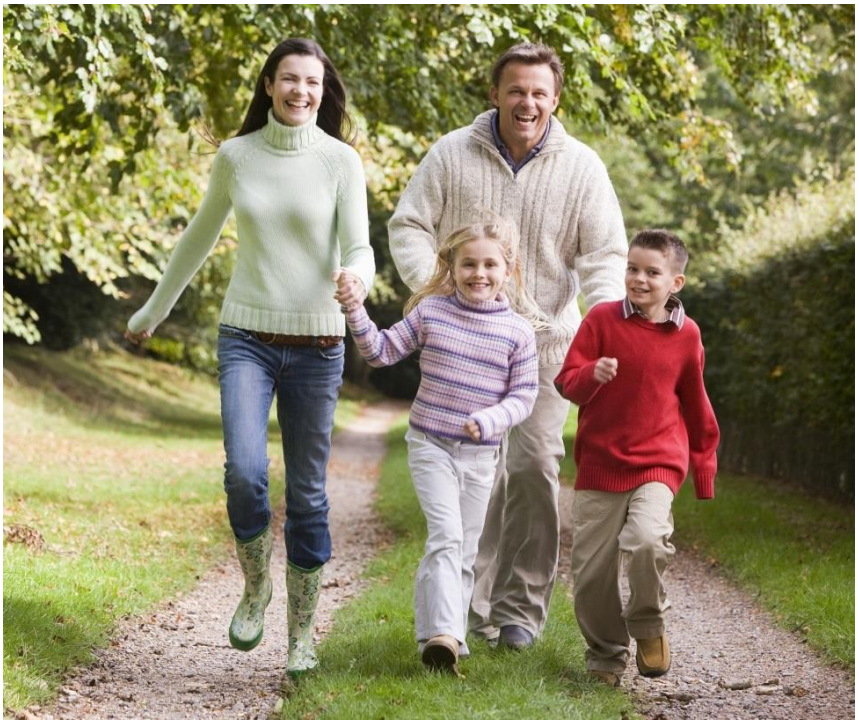

A Guide to Your NEORSD Employee Benefits 2022

NEORSD Benefits Summary
Non-Union Employees

Northeast Ohio Regional Sewer District

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Benefit Basics

As a full-time, non-union 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. Eligible dependents may be enrolled in any coverage option in which you are enrolled.

To help you better understand your benefit costs and coverage options, you may review this booklet.

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.
Your next opportunity to change your enrollment will be during the annual open enrollment period or if you experience a qualifying life event.

Questions?

If you have any questions, please reach out to Human Resources at HRDirect@neorsd.org, 216-391-6444 or by dialing 6444 from any District phone.

Qualified Life Events

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

- 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

If you experience a qualifying life event and wish to change your benefit coverage or FSA election(s) on account of the event, you must submit your change via UKG and supporting documentation (e.g., birth certificate, marriage certificate or adoption papers) within 30 days of the event.

Cost of Your Benefits

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

Benefit	Tax Treatment	Who Pays
Medical Coverage	Pretax	NEORSD & You
Dental, Vision and Hearing Coverage	Pretax	NEORSD & You
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	After-tax	NEORSD
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance	After-tax	You
Disability Coverage	Pretax	NEORSD
Flexible Spending Accounts	Pretax	You
Employee Assistance Program (EAP)	Pretax	NEORSD
457(b) Retirement Savings Plan	Pretax	You
Roth IRA	After-tax	You

Medical Coverage

NEORSD offers a preferred provider organization (PPO) medical plan, the SuperMed PPO Plan, administered by Medical Mutual of Ohio (MMOH). A PPO is a network of physicians, hospitals and other providers who have agreed to accept pre-negotiated, discounted rates for medical services. To obtain information about participating network providers in our area, visit the MMOH My Health Plan website at https://member.medmutual.com.

Plan Provisions	SuperMed PPO $500 Plan	
	In-Network	Out-of-Network
MEDICAL		
Annual deductible (Individual/family)	$500 / $1,000	
Out-of-pocket maximum (Includes deductible)	$2,000/$4,000	$3,500/$7,000
Preventive care	100%	70%*
Primary physician 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 *(waived if admitted)*	$100 copay	70%*
Non-emergency room care *(waived if admitted)*	$150 copay	70%*
PHARMACY - *You and your family members who are covered on the medical plan are automatically enrolled in the pharmacy plan administered by Express Scripts.*	EXPRESS SCRIPTS®	
Annual Rx deductible (Individual/family)	$0 / $0	
Pharmacy Out-of-Pocket Maximum *(This is separate from the medical services out-of-pocket maximum.)*	$5,600/$11,200	Not applicable
30-Day Supply **Retail Prescription Drugs**		
■ Generic ■ Brand-Name Preferred ■ Brand-Name Non-Preferred	$10 copay $20 copay $40 copay	Not covered Not covered Not covered
90-Day Supply **Express Scripts Home Mail Order Program**		
■ Generic ■ Brand-Name Preferred ■ Brand-Name Non-Preferred	$10 copay $20 copay $40 copay	Not covered Not covered Not covered

**After deductible is met*

Healthcare Buyout

Only full-time employees eligible for District healthcare benefits coverage may voluntarily decline such coverage in return for a monthly healthcare buyout payment. Part-time benefit eligible employees are not eligible to participate in the healthcare buyout payment. Dependents covered under the employee's policy are ineligible for healthcare buyout payments.

As a condition to receive healthcare buyout payments, participating employees shall acknowledge and agree that they will be solely

responsible for the payment of any healthcare costs incurred by their dependent(s) during the period of time that employees have agreed to receive healthcare buyout payments. In addition, employees must provide evidence of medical coverage from another source. The amount of the healthcare buyout is determined annually and for the 2022 plan year will be $350 a month.

Telemedicine

Cleveland Clinic Express Care® Online

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, 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

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

Dental Coverage

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

NEORSD offers a Dental PPO plan administered by Medical Mutual. The chart below is a high-level summary of your benefits. Please refer to MMOH's Benefit Booklet 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 Provision	Medical Mutual of Ohio In & Out-of-Network
Annual deductible (Individual/family)	$25 per person
Annual maximum per person	$1,500
Routine preventive services: Includes cleanings, fluoride treatments, bitewing and x-rays	100%, no deductible
Essential services: Includes fillings, periodontics, scaling and root planning, and oral surgery	80% after deductible
Complex services: Includes crowns, bridges and full and partial dentures	80% after deductible
Orthodontia (Children only up to age 26)	60% after deductible $2,000 lifetime maximum

Vision Coverage

NEORSD also offers vision coverage for you and your family. The vision plan is administered by Medical Mutual of Ohio (MMOH) utilizing the EyeMed provider network. The vision plan provides coverage when you seek care from designated vision providers. Find vision providers by visiting www.medmutual.com and searching the SuperMed PPO network within the group coverage options.

Benefit	In-Network Only	Out-of-Network Reimbursement *
Vision Exam	$10 Copay	$30
Frequency Limits		
▪ Exam	12 months	12 months
▪ Lenses	12 months	12 months
▪ Frames	24 months	24 months
▪ Contacts (instead of lenses and frames)	12 months	12 months
Frames	$0 Copay; $150 Allowance, 20% off balance over $150	$75
Lenses		
▪ Single Vision Lenses	$25 Copay	$30
▪ Bifocal Lenses	$25 Copay	$45
▪ Trifocal Lenses	$25 Copay	$60
▪ Lenticular	$25 Copay	$60
▪ Progressive	$90 Copay	$45
Contact Lenses (instead of lenses and frames)		
▪ Medically Necessary	$0 Copay, Paid in Full	$210
▪ Cosmetic	$0, then $150 Allowance	$120

Hearing Coverage

As an eligible employee of NEORSD, you and your family are provided with 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.

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

Benefit	In-Network Only
Audiometric Exam	Covered at 100% up to $40 (1 every 36 months)
Hearing Aid Evaluation Test	Covered at 100% (2 every 36 months)
Hearing Aids	Covered at 100% (2 every 36 months)
Conformity Evaluation Consists of an evaluation of the performance of the prescribed hearing aid against the prescription	Covered at 100% (2 every 36 months)

Non-Union Employees
Monthly Payroll Contributions

Full-Time/Part-Time/Interns/Temporary	Medical	Dental & Vision
Employee	$119.38	$5.11
Employee + 1	$238.47	$10.20
Employee + Family	$326.67	$14.37

Flexible Spending Accounts

The administration of the medical and dependent care flexible spending accounts will be moved to Chard Snyder effective 1/1/2022. Flexible Spending Accounts (FSAs) are designed to reduce your taxable income and save on eligible expenses not covered by insurance. They work in a similar way to a savings account. Each pay period, funds are deducted from your pay on a pretax basis and funds are available in your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum contribution is $2,750 per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

Important Information about FSAs

2022 FSA elections will be in effect from January 1 through December 31. The Health Care FSA does not rollover to the next calendar year, but it does provide a 2 ½ month "grace period." This means that if you have money left in your 2021 Health Care FSA after December 31, 2021, you will have until March 15, 2022 to use any remaining funds. All claims for reimbursement for your 2021 Health Care FSA must be sent to Basic NEO no later than March 31, 2022.

Dependent Care FSAs do not have rollover or have a grace period. Therefore, you must use any remaining funds by **December 31, 2021.**

If you choose to elect Health Care and/or Dependent Care FSA in 2022 and choose to use your 2022 funds for medical or dependent care expenses incurred on or after 1/1/2022, they will be submitted to Chard Snyder.

Please plan your contributions carefully.

Any money remaining in your FSA accounts after the claim submission deadlines will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations.

FSA elections do not automatically continue from year to year; you must actively enroll each year.

The Advantages of an FSA

With an FSA, the money you contribute is never taxed—not when you put it in the account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year.

Save on Your Taxes

Here is an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal taxes*	$15,696	$16,350
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$32,304	$31,650
Tax savings with the Medical and Dependent Care FSA	**$654**	**$0**

**This is an example only; not your actual experience. It assumes a 25% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will save on any state and local taxes as well.*

Life and Accidental Death & Dismemberment (AD&D) Insurance Coverage

Life insurance is an important part of your financial security, especially if others depend on you for support. AD&D insurance is designed to provide a benefit in the event of accidental death or dismemberment. The insurance is administered by MedMutual Life and provides Basic Life and AD&D benefit equal to 1x base annual earnings with a minimum of $50,000 and maximum of $250,000 to all eligible non-union employees, at no cost to you.

Voluntary (Optional) Life and AD&D Insurance Coverage

In addition to the District-paid Life insurance, you have the opportunity to purchase additional Life and AD&D insurance through post-tax deductions. This coverage is voluntary and 100% employee paid. You must purchase this coverage on yourself in order to purchase coverage on your spouse or children.

Evidence of Insurability (EOI): If you enroll yourself and your spouse when you are first eligible (new hire), you can elect up to the Guaranteed Issue amounts below without EOI (proof of good health). If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant and any amount of coverage requested later will require EOI before your coverage is approved.

Optional Purchase Options

Voluntary Life and AD&D		
	Coverage Options	**Guarantee Issue Amounts**
Employee	$10,000 increments up to a maximum $500,000	$100,000
Spouse	$5,000 increments up to a maximum of $250,000, not to exceed 50% of the coverage you purchase on yourself	$20,000
Child(ren) to age 18 (23 if a full-time student)	$5,000 or $10,000 ($100 for ages 15 days to 6 months)	Coverage for children is always guarantee issue

Conversion and Portability

If your life insurance - or a portion of it – ceases, you may be eligible for conversion and/or portability. Conversion allows you to convert your life benefit to an individual life insurance policy, and portability allows you to port your coverage to the Group Portable Insurance Trust Policy. Certain criteria must be met, and rates vary for both options. MedMutual Life must also receive written application and the first premium for the life insurance policy within 31 days after insurance under the policy ceases. Please see your plan certificate for complete details on both options.

Imputed Income for Employer-Provided Life Insurance

The Internal Revenue Service (IRS) requires that the value of your employer paid basic life insurance, in excess of $50,000, be reported as taxable income. The value of the amount over $50,000 is called "imputed income" and will be added to your taxable earnings. The table and example below show how imputed income is calculated.

Taxable Income per $1,000 of Protection

Employee's Age	Monthly	Annual
Under 25	$.05	$.60
25 – 29	.06	.72
30 – 34	.08	.96
35 – 39	.09	1.08
40 - 44	.10	1.20
45 – 49	.15	1.80
50 – 54	.23	2.76
55 – 59	.43	5.16
60 – 64	.66	7.92
65 - 69	1.27	13.44
70 and older	2.06	24.72

Example: John is 43 years old and earns $60,000 per year. He is eligible for $60,000 of employer-paid basic group term life insurance. The amount of taxable insurance is $10,000 ($60,000 minus $50,000). For the employer-provided basic life insurance, the annual imputed income is $12.00 (10 x $1.20). The $12.00 amount will be included on John's W-2 (Box 12) statement as taxable income for the year.

Short Term Disability

The goal of NEORSD's Disability Insurance Plans is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. NEORSD provides eligible employees with disability income benefits at no cost to employees. Coverage is automatic for full and part-time benefit eligible employees after completing ninety (90) consecutive days of full- time employment and upon meeting the waiting period as outlined in the applicable policies. Short Term Disability (STD) provides a benefit of 60% of base weekly wages to a maximum of $2,000/week.

NEORSD's Short Term Disability benefit pays 60% of your regular earnings for a maximum of 26 weeks.

DIPPO

The NEORSD Disability Insurance Premium Payment Option (DIPPO) is a voluntary benefit which allows benefit eligible employees (excluding interns) the option of paying taxes on the premium paid for STD coverage in order to receive the STD benefit payment tax-free in the event you become disabled. The cost of the premium is determined by multiplying the employee's regular earnings (base pay) by an insurance factor rate (multiplier). Regular earnings do not include overtime, longevity pay or sick leave/PTO buy out.

Example of DIPPO Calculation using the 2022 DIPPO Rate*	
Annual Regular Earnings	$50,000.00
Insurance Factor (multiplier)	.0136
Annual Insurance Premium	680.00
Bi-Weekly Regular Earnings	$1923.08
Insurance Factor (multiply)	.0136
Bi-Weekly Insurance Premium	$26.15
Paycheck	$1923.08
Add DIPPO	$26.15
Total Pay	$1949.23
Deduct DIPPO	-$26.15
Net Pay	$1923.08

Employee Assistance Program (EAP)

Sometimes life can be challenging. That's why NEORSD provides an employee assistance program (EAP) to all eligible employees at no cost to you.

The EAP is designed to provide prompt, confidential help with a range of personal and family issues that may affect all of us from time to time. You or a member of your household (spouse or dependent children) receive up to 6 free counseling sessions with an EAP professional.

EAP counselors will assist you with concerns such as:

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

The Employee Assistance Program (EAP) is a confidential outside service provided by Lifestyle EAP.

LIFESTYLE EAP
Wellness at Work

http://www.lifestyleeap.com
ID: SD18
Password: lifestyleeap

Lifestyle EAP is available 24/7/365:
(800) 989-3277

Ohio Deferred Comp - 457(b) Retirement Plan

The 457(b) Retirement Plan is a voluntary retirement savings plan that allows participants to supplement any existing retirement / pension benefit by saving and investing pre-tax dollars through payroll deductions. NEORSD offers two retirement plans – Voya and Ohio Deferred Comp.

Employee contributions may begin with the first paycheck upon election. Employees can elect to participate anytime except during open enrollment.

Roth IRA

NEORSD will offer employees the option of opening a Roth IRA through Ohio Deferred Compensation. Ohio DC participants can choose to make payroll contributions to the Roth 457 option. A Roth option lets you make contributions that are not tax deductible, but provides tax-free distributions, after certain conditions are met. Deciding whether to make Roth contributions will depend on your individual financial circumstances, such as your current income and anticipated income in retirement, and current and future tax rates. Withdrawals from a Roth IRA must meet certain requirements to be considered qualified so be sure to visit Ohio Deferred Compensation's website or call for more details.

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

Other NEORSD Provided Benefits

Leaves of Absence

NEORSD provides for leaves of absence including:

- Family Medical Leave
- Jury Duty
- Workers' Compensation Leave
- Military Leave
- Bereavement Leave
- Personal Leave
- Paid Parental Leave

Eligibility requirements and salary continuation vary depending on the type of leave as outlined in the individual policies.

Paid Parental Leave NEW!

Effective January 1, 2022, Northeast Ohio Regional Sewer District will provide up to six (6) weeks of paid Parental Leave to employees following the birth of an employee's child or the placement of a child due to adoption, foster care, or legal guardianship for events that occur on or after January 1, 2022. The purpose of this Paid Parental Leave Policy is to provide time to care for and bond with a child.

Employees must meet specific criteria to be considered eligible for this benefit. A Parental Leave Request form must be submitted to HRDirect (HRDirect@neorsd.org) at least sixty (60) days prior to the proposed date of the leave (or if the leave was not foreseeable, as soon as possible). See the Paid Parental Leave Policy for full details.

Paid Time Off

Coverage is automatic for employees beginning on the first day of full-time employment. Coverage is pro-rated the first year of employment. Full-time employees are entitled to 20 days of PTO annually increasing every five years of service, and nine scheduled holidays per year. 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 includes:

1. Retirees service time from an Ohio government employer.
2. Federal or Military service time.
3. Student employment.
4. Part-time employment.
5. Unpaid leave time except military leave.
6. Temporary or Seasonal employment.

Tickets at Work

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

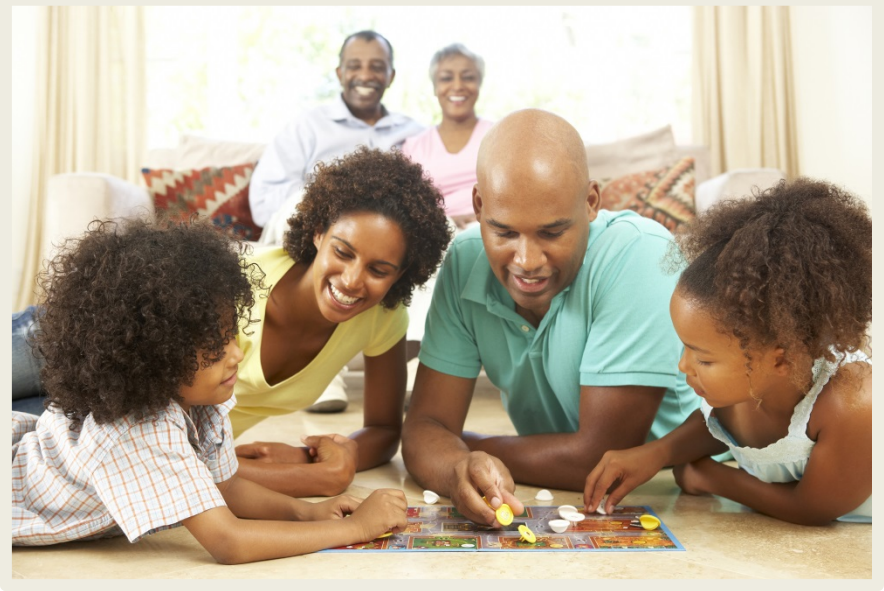
TicketsatWork.com Fun. With benefits.

Sign up today in less than 60 seconds!

1.) Go to www.ticketsatwork.com 2.)
Click "Become a Member"
3.) Create an account using our company code: **NEORSD17**

Contact Information

Plan	Provider	Phone Number	Website
Medical Plan	Medical Mutual of Ohio	(800) 540-2583	www.MedMutual.com
Dental, Vision & Hearing Plans	Medical Mutual of Ohio	(800) 540-2583	www.MedMutual.com
Flexible Spending Accounts	Chard Snyder	(800) 982-7715	www.chard-snyder.com
Life & AD&D Insurance	MedMutual Life	Contact your location's HR Business Partner	
Short-Term Disability	MedMutual Life	Contact your location's HR Business Partner	
Employee Assistance Program (EAP)	Lifestyle EAP	(800) 989-3277	www.lifestyleeap.com
457(b) Retirement Plan	Ohio Deferred Compensation	877-644-6457	www.ohio457.org
	VOYA	855-ONE-VOYA	www.voya.com



Appendix

PLEASE READ IMPORTANT NOTICES FROM NORTHEAST OHIO REGIONAL SEWER DISTRICT (NEORSD) EMPLOYEE BENEFIT PLAN ANNUAL 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 you should contact Janelle Girod, Benefits and HRIS Administrator, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach Janelle Girod 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.

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:

	PPO $500
Deductible	
In-Network	$500/$1,000
Out-of-Network	$500/$1,000
Coinsurance	
In-Network	80%
Out-of-Network	70%

If you would like more information on WHCRA benefits, contact Janelle Girod, Benefits and HRIS Administrator, 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:

1. 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.

2. 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.

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, 2021
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).

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)**.

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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)	**MONTANA – Medicaid**
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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, 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.

Model General Notice of COBRA Continuation Coverage Rights

** 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.

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;
- 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. 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, Medicaid, 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 period1 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.

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

PLAN NAME:	Northeast Ohio Regional Sewer District Health and Welfare Benefit Plan
CONTACT:	Janelle Girod, Benefits and HRIS Administrator
PHONE NUMBER:	(216) 881-6600
ADDRESS:	NEORSD, 3900 Euclid Avenue, Cleveland, OH 44115

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Janelle Girod, Benefits and HRIS Administrator, (216) 881-6600 or GirodJ@neorsd.org.

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

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

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer name Northeast Ohio Regional Sewer District (NEORSD)		4. Employer Identification Number (EIN) 34-1128332
5. Employer address 3900 Euclid Avenue		6. Employer phone number 216-881-6600
7. City Cleveland	8. State OH	9. ZIP code 44115
10. Who can we contact about employee health coverage at this job? Janelle Girod		
11. Phone number (if different from above)	12. Email address girodj@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 spouses, natural children, adopted children, children placed for adoption with you, stepchildren or legal wards from birth to the end of the calendar month in which the child attains age 26.

☐ We do not offer coverage.

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

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

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

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

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

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

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

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

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

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

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

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

Northeast Ohio Regional Sewer District

About the Guide

This benefit summary provides selected highlights of the NEORSD employee 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 information provided through this summary and the actual terms of the policies, contracts and plan documents are governed by the terms of these policies, contracts and plan documents. NEORSD reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The Plan Administrator has the authority to make these changes.