

County of Summit DD Board
2025 OPEN ENROLLMENT & PLAN PARTICIPANT NOTICES

Medicare Part D Rx Requirements

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General Notice & HIPAA Notice Requirements

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

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ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

Your prescription drug coverage provided under County of Summit DD Board is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as “creditable coverage”.

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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. County of Summit DD Board has determined that the prescription drug coverage offered by the County of Summit DD Board 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 May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable 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 County of Summit DD Board coverage may or may not be affected as well as dependent coverage. Additional guidance is available at <https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/> which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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 County of Summit DD Board 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 County of Summit DD Board changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Human Resources
Address: 2355 2nd Street, Cuyahoga Falls, OH 44221
Phone Number: (330) 634-8051

For More Information Regarding Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug 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:

1. Visit www.medicare.gov
2. 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
3. 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).

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).

Notice Regarding Wellness Program

If a Constituent Benefit Program listed is a voluntary wellness program available to all employees, it is intended to be administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program, will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Precautions deemed appropriate will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. Any questions should be directed to the Plan Administrator as listed in your Summary Plan Document.

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, “protected health information” (PHI). For information to be considered “PHI”, it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual’s “protected health information” (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual’s PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider’s treatment purposes. For example, if an individual’s Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual’s PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual’s medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and

improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan’s usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or “accounting of disclosures” of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual’s Authorization, or to the individual. An individual’s request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting **Genetic Information** An individual’s genetic information will not be used for underwriting except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan’s Responsibilities Regarding an Individual’s PHI

The Health Plan is a “covered entity” (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the “Notice”). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

**Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20210**

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your 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.

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns' and New Mothers Care Disclosure

This Plan generally does not, consistent with applicable 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 cesarean section. However, consistent with that same Federal law, this Plan 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, this Plan does not, in accordance with 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).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

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, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 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/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p>Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/</p>

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhpp.com/ Medicaid Phone: 304-558-1700 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 Phone: 1-800-362-3002	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, 2024, 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



Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

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

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Summit DD		4. Employer Identification Number (EIN) 34-6002767	
5. Employer address 2355 2nd Street		6. Employer phone number 330-634-8051	
7. City Cuyahoga Falls	8. State OH	9. ZIP code 44221	
10. Who can we contact about employee health coverage at this job? Human Resources Department			
11. Phone number (if different from above)		12. Email address	

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:



Employees who are regularly scheduled to work a minimum of 30 hours per week.



Some employees. Eligible employees are:

- With respect to dependents:



We do offer coverage. Eligible dependents are:

A legal spouse of the employee not divorces or legally separated. Spouses eligible for insurance through his or her employer are ineligible for coverage. Some exceptions apply. Coverage for employee's or spouse's children can be provided to age 26.



We do not offer coverage.



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

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

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