

# 2025 BENEFITS GUIDE



City OF Stow





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## 2025 Payroll Calendar and Holiday Schedule

January						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

December						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

 **Holidays**  
 **Pay Dates**

⌚ Whenever any such designated holiday falls on a Saturday or Sunday, the Friday preceding such Saturday, or the Monday following such Sunday, shall be paid holiday for all full time employees not scheduled normally to work on such a Saturday

⌚ Refer to your union contract, if applicable, for a full listing of paid holidays.



## HEALTHCARE SUMMARY

The City of Stow offers a PPO healthcare plan for its eligible employees and their qualified dependents.

- ❖ **Medical Mutual of Ohio** is our direct provider of major medical insurance
  - **Register** for an account <https://member.medmutual.com/registration>
  
- ❖ **Express Scripts** is our Pharmacy Benefits Manager.
  - You can **go wherever you'd like for your prescriptions (except specialty medications must be filled through Express Scripts mail order pharmacy, Accredo)**. For mail order, you must register here: <https://www.express-scripts.com/register>
  
- ❖ **Supplemental** offerings (*additional life insurance, critical illness insurance, and accident insurance*), through Guardian Insurance (different account than what is covered under vision, dental, and basic life) see [page 18](#) for a summary of information and how to enroll if interested.
  
- ❖ **Guardian Insurance** covers vision, dental, and basic life insurance:
  - More information on the [vision page](#)
  - More information can be found on the [dental page](#).



Employees able to **obtain health insurance elsewhere** are eligible to receive an annual cash bonus as an incentive to **opt out of the City's health insurance plans**. To be **eligible for the bonus**, an employee must first provide proof of health insurance coverage to the City. The annual cash bonus shall be paid in the following gross amounts: **\$1,500.00 for the employee and all dependents to opt out; \$750.00 for the opt out of single coverage employee**



## ENROLLMENT

### WHO'S ELIGIBLE

#### Employees

In general, you are eligible to participate in the Benefits Program if you are classified as a Regular Full-Time Employee.

#### Dependents

When you enroll yourself in the Benefits Program, you may also cover your eligible dependents for medical, dental, vision, and supplemental life insurance coverage.

Eligible dependents include your:

- legal spouse
- children up to age 26
- unmarried child(ren) over age 26 fully dependent on you and incapable of self-support because of a total physical or mental disability

### ENROLLMENT

- Beginning of Employment\*\*
- Life Event
- Open Enrollment 2 Weeks in Nov/Dec

Current Employees—may add, drop, or make changes to your benefits, or elect to participate in the Flexible Spending Account for the current plan year during open enrollment. These choices become effective January 1, of the plan year in which the changes are being selected. Take special note if any of the following statements are true:

New Hires and Newly Eligible Employees: you have 60 days from your hire or eligibility date to complete your enrollment.

### **\*\*WHEN COVERAGE BEGINS**

If you are an eligible employee, your coverage begins on your first date of employment, provided you complete the enrollment process within 30 days of becoming eligible.

**Note:** if the employee's spouse has coverage through his/her employer but chooses Stow's plan as primary, the City of Stow will require a **monthly spousal surcharge** of \*\*\$150.00 per month for the spouse to be on the City's plan if employee was hired on or after January 1, 2014 or \$50.00 per month for employees hired before January 1, 2014.

*\*\*some rates may differ based on collective bargaining agreement*

<https://stowohio.org/72/Intranet>

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## ENROLLMENT PAGE 2

### CHANGING YOUR BENEFITS DURING THE YEAR

Your benefit elections remain in effect for the entire calendar year, unless you have an [IRS-qualifying status change](#) (proof will be required). All changes as a result of a qualifying life event must be made within 30 days of the qualifying event. Some eligible qualifying life events include:

- **Legal marital status** – any event that changes your legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.
- **Number of dependents** – any event that changes the number of your dependents, including birth, adoption, placement for adoption, divorce, or death of a dependent, or assuming primary support of the child of an unmarried dependent child.
- **Employment status** – any event in which employment begins or ends for an eligible dependent; the gain or loss of eligibility due to a change in full-time to part-time status or vice versa.
- **Dependent status** – any event which causes your married or unmarried dependent up to age 26 to satisfy or cease to satisfy eligibility requirements due to age, or similar circumstances under your plan.
- **Medicare eligible status** – you or your spouse become Medicare eligible.

If you have a qualifying life event during the plan year that allows for a change in benefit coverage, you can request a change in enrollment that is consistent with your change in status. To do so, contact the HR department within 30 days of the event.

If at any time during the year your enrolled dependents no longer meet the eligibility requirements, please notify Human Resources to remove the individuals from coverage





## GLOSSARY

- **Coinsurance** - A certain percentage you must pay each benefit period after you have paid your deductible. This payment is for covered services only. Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.
- **Copay** – For the City of Stow, a copay applies to the Rx plan until the maximum out of pocket is reached and then there will no longer be a co-pay for prescriptions.
- **Deductible** - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on a calendar year.
- **Out-of-pocket Cost** - Out-of-pocket costs vary by plan and each plan has a maximum out-of-pocket (MOOP) cost. Out of pocket maximum includes copayments + deductible + coinsurance.

**Deductibles, coinsurance and out-of-pocket maximum all work together.**

**Before reaching your deductible** you pay for all health care services, including doctor visits, hospitalizations, outpatient care, tests, prescription drugs, etc. **After you reach your deductible**, coinsurance kicks in. **Coinsurance** is a percentage you and Medical Mutual pay for in-network services. Our plan's coinsurance is 20%. Coinsurance continues until you reach your plan's out-of-pocket maximum.

Example: let's say you reach your \$450.00 deductible. You're not feeling well and go to an urgent care center to get checked out. You wind up needing \$200 worth of services during that visit. Since your coinsurance is 20%, Medical Mutual will pick up \$160 of that visit and you will pay the other \$40.

**Once you reach the out of pocket maximum**, Medical Mutual picks up all the in-network covered health care costs. You will continue to pay premiums (the amount taken out each pay) after reaching your out-of-pocket maximum.



## MEDICAL

### 2025 MEDICAL CONTRIBUTIONS - PER PAY

Single	\$70.00
Family	\$140.00

### OUR MEDICAL PLANS

- Provide a wide range of health care services.
- Offer network providers whose pre-negotiated rates will save you money.
- Allow you to use out-of-network providers, if you wish.

Learning as much as possible about the plan can help you make more informed choices regarding your needs and those of your covered dependents. **Click to review the [Medical-at-a-glance chart](#)**. The chart will help you make an informed decision about the coverage that best meets your needs and those of your covered dependents.

### YOUR OPTIONS FOR MEDICAL COVERAGE

Our plan provides high quality, affordable medical care, including doctors' visits, preventive care, Lasik eye surgery, hearing aids, hospitalization, and emergency care. Review the benefit summary chart on the next page to learn as much as possible about the plan.



### HOW THE PLAN WORKS

The plan is a Preferred Provider Organization (PPO) Plan, administered by Medical Mutual. It gives you the freedom of receiving care within the network or from out-of-network providers. When you use providers within the network, the plan pays a higher level of benefits' and you generally won't have to file any claim forms.

If you prefer to go out-of-network for medical care, you will be reimbursed at a lower benefit level. You may also have to file a claim for reimbursement.

**Please note:** If a preferred provider refers you for covered services to another provider (such as a lab or specialist), make sure the provider you have been referred to is also a preferred provider. If the provider you use is not a preferred provider, your out-of-pocket costs will be higher, even if you are referred by a preferred provider.



We also offer Teladoc Health, a free service if on demand appointment. For pre-scheduling doctor's appointments. Teladoc gives you access to U.S. board certified doctors and nurse practitioners 24/7. Download the app on your phone or connect here:

<https://www.teladochealth.com/>

Questions about a claim or need a new ID? Contact our broker here: [TObenefits@tayloroswald.com](mailto:TObenefits@tayloroswald.com)



## MEDICAL AT-A-GLANCE

### MEDICAL BENEFITS-AT-A-GLANCE

Type of Services	In-Network You Pay	Out-of-Network* You Pay
<b>Deductible</b> (per calendar year) (Individual / Family)	\$450 / \$900	\$950 / \$1,900
<b>Coinsurance Limit</b> (excludes deductible) (Individual / Family)	\$350 / \$700	\$350 / \$700
<b>Out-of-pocket Maximum</b> (includes deductible, coinsurance, and medical/Rx copays) Individual / Family (per calendar year)	\$800 / \$1,600	\$1,300 / \$2,600
<b>Coinsurance</b>	20% after deductible	40% after deductible
<b>Emergency Services</b>		
Emergency – Emergency Room	20% after deductible	20% after deductible
Emergency Services – all other related charges	20% after deductible	40% after deductible
Non-Emergency – Emergency Room	20% after deductible	40% after deductible
Non-Emergency Services – all other related charges	20% after deductible	40% after deductible
Urgent Care Provider Office Visits	20% after deductible	40% after deductible
<b>Mental Health Care, Drug Abuse/Alcoholism</b>		
Inpatient Mental Health Care, Drug Abuse and Alcoholism Services	Benefits paid are based on corresponding medical benefits	Benefits paid are based on corresponding medical benefits
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services		
Biologically Based Mental Illness Services		
<b>Outpatient and Routine Services</b>		
Well Child Exam	\$0 Copayment	40% after deductible
Well Child Immunizations	\$0 Copayment	40% after deductible
Well Child Laboratory Services	\$0 Copayment	40% after deductible
Outpatient Occupational, Physical and Chiropractic Visits	20% after deductible	40% after deductible
Outpatient Speech Therapy Services	20% after deductible	40% after deductible
Outpatient Allergy Testing and Treatments	20% after deductible	40% after deductible
Routine Physical Examinations	\$0 Copayment	40% after deductible
Routine Testing and Endoscopic Services	\$0 Copayment for first \$200 per benefit period, then 20% after deductible	40% after deductible
<b>Other Services</b>		
Ambulance Services	20% after deductible	40% after deductible
Home Health Care Services	20% after deductible	40% after deductible
Hospice Services	20% after deductible	40% after deductible
Organ Transplant Services	20% after deductible	40% after deductible
All Other Covered Services	20% after deductible	40% after deductible

\* Out-of-Network reimbursement is based on what the insurance carrier deems as reasonable & customary. You will be responsible for paying the difference between amount billed and reasonable & customary, in addition to the coinsurance levels above.



## PRESCRIPTION DRUGS

### PRESCRIPTION DRUGS

When you enroll in the City of Stow's medical insurance plan, you automatically receive prescription drug coverage. Coverage is provided through your Medical Mutual health insurance card.

Point of sale pharmacy transactions can be handled at any participating pharmacy. For retail prescriptions, you may purchase up a 30-day or 90 day supply of covered drugs at a participating retail pharmacy. You must present your ID card at the participating pharmacy and make the required out of pocket copay.

### Home Delivery Service

The plan also includes a home delivery order service through [Express Scripts](#). You are able to get a 90-day supply of covered drugs through [Express Scripts](#), which will be delivered directly to your home.

**To use the home delivery program, you must sign up for this service through [Express Scripts](#).**

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***Rx Co-Pays do not apply to your deductible but do count toward your out-of-pocket maximum***

#### Prescription Drugs Retail

- Tier 1 \$10 generic
- Tier 2 \$25 brand name formulary
- Tier 3 \$40 brand name non-formulary
- Tier 4 25% max for specialty up to \$200

#### Prescription Drugs Mail Order

- Tier 1 \$20 generic
- Tier 2 \$50 brand name formulary
- Tier 3 \$80 brand name non-formulary

Questions about a claim or need a new ID? Contact our broker here: [TObenefits@tayloroswald](mailto:TObenefits@tayloroswald)

<https://stowohio.org/72/Intranet>

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## DENTAL & ORTHODONTIC INSURANCE

Dental Insurance is offered through Guardian Insurance. For a full listing of in-network dentists, visit <https://www.guardianlife.com/find-a-dentist>. Below is a brief overview of the coverage.

- ❖ Dental Overall Benefit: \$1,500 per calendar year\*\*
- ❖ Deductible: Single \$50; Family \$100
- ❖ Preventive & Diagnostic: 100%
- ❖ Basic Services: 80%
- ❖ Major Services: 50%
- ❖ Implants: 50%
  
- ❖ Orthodontia: 50%
- ❖ Orthodontics: Overall Lifetime benefit \$1,500 per covered member

**\*\*Maximum Rollover option:** you can rollover part of your annual dental benefit if your claims do not exceed \$700 in a year.

Here's how it works: your claims don't exceed \$700 in a calendar year, you are able to forward an additional \$350 into the following calendar year for services that are out of network or up to \$500 for in network services. So that means going into the following calendar year, you have the rollover amount plus the annual \$1,500 allowance. The max amount you can have in carry over funds for one year is \$1,250.00.

Questions about a claim or need a new ID? Contact our broker here: [TObenefits@tayloroswald](mailto:TObenefits@tayloroswald)



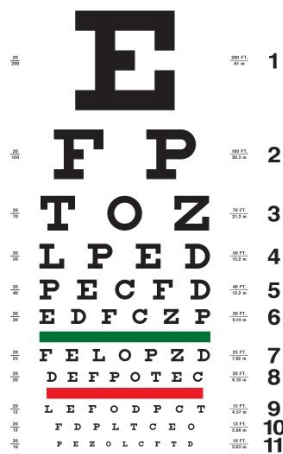
<https://stowohio.org/72/Intranet>



## VISION BENEFITS

Vision benefits are offered through Guardian's Davis Vision providers.

Below is a brief overview of covered services. **For a complete list of coverage, refer to <https://microsite.davisvision.com/guardian/>**



- ❖ Eye exam: \$10 copay
- ❖ Lenses: \$25 copay
- ❖ Frames \$130 allowance + 20% balance; \$130 allowance (Costco, Walmart, and Sam's Club)
- ❖ Contacts: \$130 allowance + 15% balance
- ❖ "You and your eligible dependents, may receive one exam every twelve (12) months on a calendar year
- ❖ You may receive lens or contacts every 12 months; and frames every 24 months

Questions about a claim or need a new ID? Contact our broker here: [TObenefits@tayloroswald](mailto:TObenefits@tayloroswald)



<https://stowohio.org/72/Intranet>



## FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) are voluntary accounts that allow you to use your before-tax pay for certain health care expenses and dependent care expenses as determined by IRS regulations. **You can set up two separate accounts—one for eligible health care expenses and one for qualified dependent care expenses.** These are two separate accounts for two separate purposes. The monies in one account can't be used to satisfy expenses in the other account. You can participate in either of these accounts or both — or none at all — depending on your needs. [Medical Mutual My Spending Accounts](#) is the claims administrator for the FSA Program.

### HEALTH CARE FSA

**Contributions:** you may contribute up to **\$3,300 in 2025** as a before-tax contribution to your Health Care FSA. Additionally, you may **carry over \$660.00 of 2024 into 2025.**

### Eligible Dependents

In general, an eligible dependent under the Health Care FSA is anyone you list as a dependent on your federal income tax return. This includes your immediate family members, a close relative, or other person whose primary residence is your home and for whom you provide over 50% support

### USING YOUR HEALTH CARE FSA DEBIT CARD

Per Internal Revenue Service (IRS) regulations, your Debit Card may only be used at health care providers who have a health care-related merchant category code (such as physicians, dentists, vision care offices, hospitals, and other medical care providers) or at grocery stores, discount stores and pharmacies who utilize an Inventory Information Approval System (IIAS). You may not use the Debit Card at any merchant, including pharmacies, that do not have a healthcare-related merchant category code unless that merchant or pharmacy utilizes an IIAS.

### ELIGIBLE HEALTH CARE EXPENSES

If you set up a Health Care FSA, you can be reimbursed for eligible expenses that you or your dependents incur after your effective date and during the calendar year in which you participate in the Plan.

*Examples* of eligible health care expenses, to the extent not covered by another plan, include:

- Copayments, deductibles, and coinsurance not covered by medical or dental insurance
- Uninsured expenses, such as hearing aids, eyeglasses, contact lenses and certain eye surgeries
- Orthodontia
- Diabetic supplies
- Smoking cessation programs
- Fertility services

### PAYING YOUR HEALTH CARE EXPENSES

There are two ways to pay for eligible expenses:

- FSA Claim Form – You pay your health care providers directly and then file a claim for reimbursement. Simply complete a health care FSA claim form and submit the form by mail or fax along with the receipts. The form is available by logging on to [www.MedMutual.com/member](http://www.MedMutual.com/member) or by calling Member Services at 1-800-525-9252.
- Debit Card – You can use this card to pay for eligible health care expenses at any healthcare provider or approved merchant. With the Debit Card, participants have instant access to the money in their FSA, which is automatically drawn from their account as purchases are made.

You can shop online too. Here are *SOME* resources but you can search any FSA eligible products online:  
[FSA Store](#) - or -  
[Amazon FSA Store](#) - or -  
[Target](#) - or many others by searching online



## FLEXIBLE SPENDING ACCOUNTS PAGE 2

### DEPENDENT CARE EXPENSES

For a complete list of eligible and ineligible health and dependent care expenses visit [www.IRS.gov](http://www.IRS.gov) and review Publications 502 & 503. A list can also be obtained from your local IRS office.

### DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

#### Contributions

In the Dependent Care FSA, **you may contribute up to \$5,000 per year**. The \$5,000 annual maximum applies to all contributions made by you and your spouse to a dependent care account. If you are married and filing separately for federal income tax purposes, you may elect to contribute up to \$2,500 per year

#### Eligible Dependents

You can be reimbursed for day care expenses you have in a plan year, if the expenses are necessary to allow you and your spouse—if you're married—to work. These services may be provided inside or outside your home by babysitters, companions or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

Your **day care expenses** must be for:

- Your dependent under age 13 who lives with you for more than half the year and for whom you can claim an exemption
- A child under age 13 for whom you have custody if you are divorced or legally separated
- Your spouse who is physically or mentally incapable of self-care
- A dependent of any age, such as an elderly parent or other adult dependent, who meets all of the following criteria:
  - » Is physically or mentally incapable of caring for himself or herself,
  - » Receives over half of his or her support from you,
  - » Lives with you for more than half the year, and
  - » Is your sibling, step-sibling or any of their descendants; a parent or step-parent or any of their ancestors; an aunt, uncle, niece, or nephew; children or parents-in-law; or an unrelated individual who shares your residence as a member of the household.





## **CONTACT INFORMATION**

BENEFIT	CONTACT INFO
<b>Medical Mutual of Ohio for <u>major medical</u></b>	Register for an account: <a href="https://member.medmutual.com/registration">https://member.medmutual.com/registration</a> You will need your Medical Mutual ID Number from your card
<b>Express Scripts for <u>prescriptions</u></b>	Register for an account: <a href="https://www.express-scripts.com/register">https://www.express-scripts.com/register</a>
<b>Guardian for <u>dental and vision</u></b>	Dental providers: <a href="https://www.guardiananytime.com/fpapp/search">https://www.guardiananytime.com/fpapp/search</a>  Vision providers: <a href="https://microsite.davisvision.com/guardian/">https://microsite.davisvision.com/guardian/</a>
<b><u>Flexible Spending</u> (both healthcare expenses and dependent care expenses)</b>	<a href="http://www.medmutual.com">www.medmutual.com</a>

**Questions about a claim or need a new ID? Contact our broker here: [TObenefits@tayloroswald](mailto:TObenefits@tayloroswald)**

Internal Contacts	Name and email address	Phone Number
<b>Payroll</b> questions	Tracey Humes <a href="mailto:thumes@stow.oh.us">thumes@stow.oh.us</a>	330.689.2835
	-OR-	
	Jamie Twigg <a href="mailto:jtwigg@stow.oh.us">jtwigg@stow.oh.us</a>	330.689.2834
<b>Benefits</b> questions	Jen Sinatra <a href="mailto:jsinatra@stow.oh.us">jsinatra@stow.oh.us</a>	330.689.2822



## 457(B) PLANS AND ROTH PLANS

Deferred compensation plans can be a great savings vehicle to defer income now and withdraw it at some point in the future (usually upon retirement). This is a pre-tax benefit and any investment earnings on these dollars are allowed to accumulate without current federal income tax. For more information visit: <https://www.irs.gov/retirement-plans/irc-457b-deferred-compensation-plans>

Roth 457(b) contributions are made after-tax dollars are withdrawn, but do not required taxes to be paid at a later date once withdrawing funds.



- These programs are voluntary.
- The City of Stow doesn't endorse or provide guidance on any of its voluntary offerings.
- If you select to participate in any of these plans, please contact the vendor directly. The city of Stow will receive your selection to participate from any of the following vendors and automatically deduct from your paycheck.

### 3 companies from which to choose

#### **Equitable – offers both 457(b) and Roth 457(b)**

<https://equitable.com/retirement>

David Peterson

330-664-1802

[David.Peterson2@equitable.com](mailto:David.Peterson2@equitable.com)

#### **Ohio Deferred Compensation – offers both 457(b) and Roth 457(b)**

<https://www.ohio457.org/home>

Chris Waters

330-328-5982

[Waterc3@nationwide.com](mailto:Waterc3@nationwide.com)

#### **Voya – offers only 457(b)**

<https://www.voya.com/>

Jason Dubeansky

Tel.: (216) 447-3751

[Jason.Dubeansky@voyafa.com](mailto:Jason.Dubeansky@voyafa.com)



## EMPLOYEE ASSISTANCE PROGRAM

Our Employee Member Assistance Program, offered through [Ease@Work](#), is a **confidential** counseling and referral service available to you, your dependents, and all members of your household for up to 6 sessions per issue per year for counseling and coaching. EAP is available to you at **no cost** to provide assistance and guidance whenever life events interfere with health and wellness or your ability to excel at work or at home.

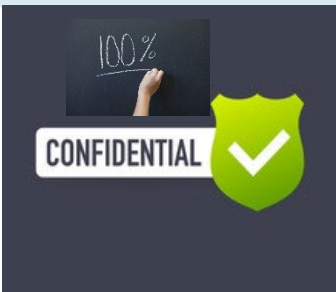
**HOW TO ACCESS Ease@Work:**  
 Call 1-800-521-3273 or visit [www.easeatwork.com](http://www.easeatwork.com). For access into the Member Portal, you must create an account using Company Code "cityofstow"

### PROGRAM HIGHLIGHTS

Through [Ease@Work](#), you and your family have access to trained counselors who can address issues such as stress, depression, parenting, divorce, alcohol abuse, drug abuse, workplace issues, family matters, work/ life balance, financial issues, marital problems, child and elder care, and legal problems.

Services are available to you and your household members for assistance with these and many other matters:

- Depression
- Stress and anxiety
- Marital or life partner problems
- Family concerns
- Child and parenting issues
- Grief and loss issues
- Referrals and discounts
- Local resources for information and assistance
- Tips for productive work and healthy families
- Eldercare support
- Financial Wellness



<https://stowohio.org/72/Intranet>



## MEDICARE

Medicare is the health insurance program run by the Federal Government. It is available to those 65 and older, those under 65 with certain disabilities, and those with end-stage renal disease.

**Our Taylor Oswald partner** offers personalized service to you and your family members so you can choose the right Medicare coverage for your individual situation. Call an InsureOne Benefits Medicare Enrollment Specialist at 1-800-722-7331 for answers to these and all your Medicare questions:

- When do I enroll in Medicare?
- How do I enroll in Medicare?
- What are the four parts of Medicare?
- What is the right type of Medicare coverage for me?



These services are provided by a knowledgeable and licensed specialist at no charge to you.

They will:

- Identify the plans and companies that meet your personal needs.
- Look up the doctors and hospitals you use to make sure they are part of the plan provider list.
- Look up the prescription drugs you take to make sure they are covered.
- Review and explain the plan benefits and coverage.
- Provide Monthly Premium rates.
- Help you complete your enrollment application and in some cases take your application over the phone.
- Obtain your application approval from the insurance company.
- Provide you with a personal Welcome Kit and Document Envelope to retain all of your personal insurance information.

Complete a Medicare Personal Information Sheet at our secure site to get started:

<https://oswaldsecure.formstack.com/forms/medicare>

This will help our Medicare Enrollment Specialist better understand your needs and provide the best recommendations for your individual situation. Call 1-800-722-7331 today to get your questions answered.



## VOLUNTARY PRODUCTS

### VOLUNTARY LIFE AND AD&D

- ❖ You may purchase additional life insurance for **yourself** between \$10,000 - \$300,000
- ❖ You may purchase life insurance for your **spouse** between \$5,000 - \$250,000\*\*
- ❖ You may purchase life insurance for your **child(ren)** from \$2,000 - \$10,000
- ❖ There is a **reduction** in age to 50% at **age 70**  
*\*\*The guarantee issue is \$100,000 for employee, \$30,000 for spouse, and \$10,000 for dependent children which means if you elect more than the guaranteed issue amount, you may be required to provide medical documentation to the insurance company.*

### ACCIDENT INSURANCE

- ❖ Covers a portion of cost if admitted to the hospital, confinement, ambulance fees, ER visits, and more
  - ❖ Coverage is within 24 hours of accident
  - ❖ These plans are portable (if you left employment you could take this policy with you and pay on your own)
  - ❖ Your monthly cost for this benefit is:
    - You only \$17.23
    - You and Spouse \$24.26,
    - You and Child(ren) \$25.30
    - You, Spouse and Child(ren) \$32.33
- Benefit Amount:
- You: \$25,000
  - Spouse: \$12,500
  - Child: \$5,000

### CRITICAL ILLNESS INSURANCE

- ❖ Coverage for some types of critical illness up to a max of \$30,000\*
- ❖ Spouses are available to be covered\*
- ❖ Child(ren) are available for coverage up to age 26\*
- ❖ There is no pre-existing condition clause
- ❖ These plans are portable (if you left employment you could take this policy with you and pay on your own)
- ❖ There is a wellness benefit for each family member – this means you will get up to \$100 per covered family member for eligible wellness initiatives (can be flu shot, annual physical, blood work, etc.) †

*\*\*The guarantee issue is \$30,000 for employee, \$30,000, and 25% of total amount selected by the employee for child(ren) which means if you elect more than the guaranteed issue amount, you may be required to provide medical documentation to the insurance company.*

*†These are only examples of what may be covered under the wellness benefit*

### To enroll or have questions about existing claims

**Contact Shirley Hughes**, Carriage Group Benefits  
Phone: [330.523.5423](tel:330.523.5423) | Fax: [330.523.5435](tel:330.523.5435) |  
Email: [shughesh@carriagegb.com](mailto:shughesh@carriagegb.com)  
2034 Schiller Ave., Suite B Cuyahoga Falls, OH 44223  
or click below to send an email to Shirley

**ENROLL NOW**



### **Contact Kevin D. Kovach** for specific questions about any of these products

Principal – Health & Life, Carriage Group Benefits  
Phone: [330.523.5423](tel:330.523.5423) x1102 | Fax: [330.523.5435](tel:330.523.5435) | Email: [kkovach@carriagegb.com](mailto:kkovach@carriagegb.com)  
2034 Schiller Ave., Suite B Cuyahoga Falls, OH 44223

*\*\*Please note, new hires have 31 days from date of hire to enroll. Any date outside of the 31 days will have to wait until open enrollment. Guarantee issue amounts only within the 31 days of hire or for existing employees, during the 2024 open enrollment season. As with any policy, please be sure you understand fully what the cost is, and what the policy covers. The City of Stow assumes no liability for these voluntary products.*



## FITNESS BENEFITS

### LifeCenter Plus – Hudson

- ❖ \$50\*/month Single membership
  - ❖ \$25\*/month for spouse
  - ❖ \$12\*/month per child 7+
  - ❖ \$10 ID card fee children ages 0-6
- \*plus 6.75% tax*

Zero enrollment fee

Details online here:

<https://www.lifecenterplus.com>

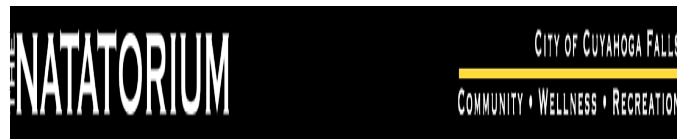


### Natatorium – Cuyahoga Falls

- ❖ \$35/month or \$420/year single membership.
- ❖ \$60/month or \$720/year household of 2
- ❖ \$70/month or \$840/year household of 3
- ❖ \$80/month or \$960/year household of 4

Annual membership requires a contract and \$2.00 processing fee per month

Details online here: <https://www.fallsnat.com/>



### LifeStyles – Cleveland Clinic Akron General

Locations: Bath, Green, and Stow

Level Enrollment	Fee*	Dues*	*Does not include state sales tax
Individual	\$175	\$59.50	
Couple	\$225	\$91.00	
Family	\$250	\$118.50	

**Enrollment Fee Discounts available:** (Discounts cannot be combined)

Senior (60+): 20% off Enrollment Fee only

Cleveland Clinic Akron General Clinical Services: 30% off Enrollment Fee only

Military: 50% off Enrollment Fee only





## OPERS

As a member of OPERS  
**you don't pay into Social Security**

As a member of OPERS you do not pay into Social Security. OPERS replaces Social Security for Ohio public employees.

### **Instead, you pay into OPERS**

You contribute a percentage of your salary to OPERS, and your employer contributes an amount equal to a percentage of your salary. OPERS invests this money for your retirement.

### **How much do I contribute to OPERS?**

As a member, you contribute **10%** of your salary toward your retirement. Your employer contributes an amount equal to **14%** of your salary.

That means an amount equal to **24%** of your total salary is being invested by OPERS.

See the [FAQ page for more](#) details

**Please note:** the Windfall Elimination Provision can affect how Social Security calculates your retirement or disability benefit. As a government agency, the city of Stow does not withhold social security and therefore any monies you've paid into Social Security may be affected. Visit the Social Security Administration for more information by clicking [here](#)



## OP&F

As a member of Ohio Police & Fire Pension Fund (OP&F)

### **You don't pay into Social Security**

OP&F replaces Social Security for Ohio public employees.

### **Instead, you pay into OP&F**

You contribute 12.25% of your salary to OP&F, and the city of Stow contributes 7.25% for police officers, totaling 19.5% toward your pension and 11.75% for firefighters, totaling 24% of your salary toward your pension. OP&F invests this money for your retirement.



**Please note:** the Windfall Elimination Provision can affect how Social Security calculates your retirement or disability benefit. As a government agency, the city of Stow does not withhold social security and therefore any monies you've paid into Social Security may be affected. Visit the Social Security Administration for more information by clicking [here](#)

To **register** for OP&F look [here](#)

**Frequently asked questions** related to OP&F [here](#)

For a **Member Guide** click [here](#)





## 2025 IMPORTANT NOTICES AND DISCLOSURES

**ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE OR ABOUT TO BECOME ELIGIBLE?  
IF SO, PLEASE READ ON:**

### Notice of Creditable Coverage

Your prescription drug coverage provided under the City of Stow's plan 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".

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. The City of Stow has determined that the prescription drug coverage offered by Medical Mutual 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 15<sup>th</sup> through December 7<sup>th</sup>. 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 Employer's 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.



## 2025 IMPORTANT NOTICES AND DISCLOSURES

### Notice of Creditable Coverage, page 2

#### **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 the 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 Jen Sinatra, HR Director; City Hall, 3760 Darrow Road, Stow, Ohio 44224 or phone Number: 330.689.2822 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 the City of Stow's changes. You also may request a copy of this notice at any time.

#### **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](http://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](http://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).**



## 2025 IMPORTANT NOTICES AND DISCLOSURES

### 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.



## 2025 IMPORTANT NOTICES AND DISCLOSURES

### Uses and Disclosures of Protected Health Information (PHI) (continued)

**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.



## 2025 IMPORTANT NOTICES AND DISCLOSURES

### Uses and Disclosures of Protected Health Information (PHI) (continued)

**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).

**Genetic Information.** An individual's genetic information will not be used for under writing 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. 2020**



## 2025 IMPORTANT NOTICES AND DISCLOSURES

### **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.



## 2025 IMPORTANT NOTICES AND DISCLOSURES

### Newborn's and New Mother's 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](http://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](http://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](http://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, 2022. Contact your State for more information on eligibility.



# 2025 IMPORTANT NOTICES AND DISCLOSURES

ALABAMA - Medicaid		Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447
ALASKA - Medicaid		The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>
ARKANSAS - Medicaid		Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid		Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)		Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442
FLORIDA - Medicaid		Website: <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
GEORGIA - Medicaid		Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131
INDIANA - Medicaid		Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid: Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584
IOWA – CHIP (Hawki)	Medicaid and	Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562
KANSAS - Medicaid		Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884
KENTUCKY - Medicaid		Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a> KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>
LOUISIANA - Medicaid		Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE - Medicaid		Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: -800-977-6740 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP		Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a> Phone: 1-800-862-4840
MINNESOTA - Medicaid		Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739
MISSOURI - Medicaid		Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
MONTANA - Medicaid		Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084
NEBRASKA - Medicaid		Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178



NEVADA - Medicaid	Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid	Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPPA program: 1-800-852-3345, ext 5218
NEW JERSEY - Medicaid and CHIP	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
NEW YORK - Medicaid	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100
NORTH DAKOTA – Medicaid	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742
OREGON - Medicaid	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a> Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA - Medicaid	Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
TEXAS - Medicaid	Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
VERMONT - Medicaid	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP	Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
WEST VIRGINIA - Medicaid	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
WYOMING - Medicaid	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)  
Ext. 61565

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4,



# 2025 IMPORTANT NOTICES AND DISCLOSURES

## 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.<sup>1</sup>

**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 [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](http://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.



# 2025 IMPORTANT NOTICES AND DISCLOSURES

## 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 City of Stow		4. Employer Identification Number (EIN) 34-6002740	
5. Employer address 3760 Darrow Road		6. Employer phone number 330.289.2822	
7. City Stow	8. State OH	9. ZIP code 44224	
10. Who can we contact about employee health coverage at this job? Jen Sinatra, HR Director			
11. Phone number (if different from above)		12. Email address jsinatra@stow.oh.us	

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:

Regular, full time employees

Some employees. Eligible employees are:

• With respect to dependents:

We do offer coverage. Eligible dependents are:

- legal spouse
- children up to age 26
- unmarried child(ren) over age 19 fully dependent on you and incapable of self-support because of a total physical or mental disability

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.



# 2025 IMPORTANT NOTICES AND DISCLOSURES

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? \$63.75 \_\_\_\_\_

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? \$ 68.50 \_\_\_\_\_

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 80 percent of such costs (Section 9801(c)(2)(C)(ii) of the Internal Revenue Code of 1986)