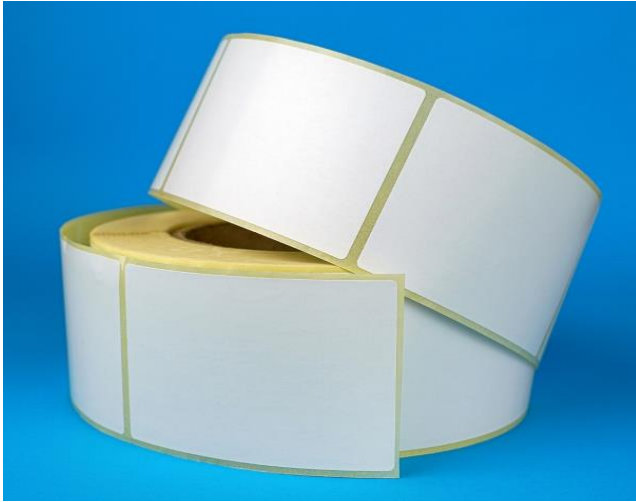


2025-2026



I.D. Images **BENEFIT GUIDE**

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Enrollment benefits are available under the following conditions

- Upon hire – must enroll within 30 days of hire date . Benefits are effective first of the month following 60 days of employment.
- Open enrollment – existing employees can enroll or make changes
- Qualifying life event – proof of life event must be provided in order to enroll in benefits

I.D. Images is pleased to announce our 2025-26 benefits program, which is designed to help you stay healthy, feel secure, and maintain a life/work balance. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions located at <https://idimages.eebenefits.site/>. Listed below are the I.D. Images benefits available during open enrollment:

- Medical & Rx
- Dental
- Vision
- Life and AD&D
- Vol Life and AD&D
- Health Savings Accounts
- Disability
- Accident Insurance

Open Enrollment Will take place in June.

If you would like to make changes to your benefit elections, changes will be made through Paycom. Even if you decide not to elect a benefit change for 2025-26 it is important to review any beneficiary information.

If you do not complete the enrollment process during the designated time, you may not be eligible to enroll again until an open enrollment period and enrollment for some benefit plans may require proof of insurability in the form of health questionnaires.



Eligibility

Full-time employees working 30 hours or more per week are eligible for benefits.

Eligible Dependents are defined as:

- *Your legal spouse or qualified domestic partner.*
- Dependent “child” up to age 26. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship.

When Coverage Begins:

- Newly hired employees and dependents will be effective 1st of the month following first 60 days of employment.
Example: if you’re hired on Sept 5th, coverage begins Dec 1st. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a family status event.

Changing Coverage During the Year:

- You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. Spousal or dependent coverage cost does not qualify as a life event. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event. For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.*



Coverage	Dependent Age/FT Student Status	Termination of Coverage Date
Medical	To age 26	End of Month
Life	To age 26	Birthdate
Dental	To age 26	End of Month
Vision	To age 26	End of Month

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler, and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease and is an important part of maintaining your medical health. I.D. Images offers a dental plan through **Cigna**. Your dental plan offers in- and out-of-network benefits utilizing Cigna’s networks. To see a full, comprehensive list, please refer to the Summary of Benefits.

Level of Care	Standard Option PPO	
Benefit	In-Network	Out-of-Network
Deductible Individual / Family	\$50 / \$150	\$50 / \$150
Max Annual Benefit for Services Applied to preventive, basic and major	\$1250	\$1250
Preventative Care - Periodontal maintenance - Oral exams - Cleaning	100%	100%
Basic Care - Fillings - Simple extractions - X-rays	80%	80%
Major Care - Bridges & dentures - Crowns, Inlays, Onlays - Oral surgery (excluding extractions)	50%	50%
Orthodontia	Not Covered	Not Covered



Provided by Cigna

Cigna vision offers affordable vision care solutions. In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, and contact lenses instead of eyeglasses.

Vision Plan		
Feature	In-Network	Out-of-Network
Exam (once a year)	\$10 copay	\$45 allowance
Frames (once every two years)	100% to \$130; 20% off Balance	\$71 allowance
Lenses (once a year)	\$25 copay	\$32 to \$80 allowance
Contact Lens (once a year)	100% to \$130; 15% off Balance	\$105 allowance

Did you know? You receive 20% off any item not covered by your Cigna plan, including non-prescription sunglasses (excluding professional services)



HEALTH PLANS



Medical coverage is provided through **Cigna**. The medical coverage includes a national network of physicians, specialists and hospitals. I.D. Images offers employees medical coverage through Cigna's Open Access Plus Network. Below is a snapshot of what is covered under the plan. To see a full, comprehensive list, please refer to the Summary of Benefits. Plan Costs are communicated separately.

	OAP \$7,500 (Base)		OAP \$2,500 (Buy-up)		HDHP \$3,750 w/ HSA	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Contract Year Deductible	\$7,500 Individual / \$15,000 Family		\$2,500 Individual / \$5,000 Family		\$3,750 Individual / \$7,500 Family	
After Deductible Plan Pays	70%	50%	80%	50%	90%	70%
Contract Year Out-of-Pocket Maximum (includes Rx)	\$9,200 Individual / \$18,400 Family		\$7,500 Individual / \$15,000 Family		\$6,450 Individual / \$12,900 Family	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Preventive Care for Adults & Children	100%	50%, after deductible	100%	50%, after deductible	100%	70%, after deductible
Doctors Office Visits Primary Care / Specialist	\$50 Copay / \$75 Copay after deductible	50%, after deductible	\$35 Copay / \$50 Copay	50%, after deductible	90%, after deductible	70%, after deductible
Inpatient / Outpatient Facility Charges	70%, after deductible	50%, after deductible	80%, after deductible	50%, after deductible	90%, after deductible	70%, after deductible
Emergency Room Facility Charges*	\$500 Copay		\$500 Copay		90%, after deductible	70%, after deductible
Urgent Care	\$75 Copay	50%, after deductible	\$75 Copay	50%, after deductible	90%, after deductible	70%, after deductible
Complex Imaging (MRI, CAT, PET)	70%, after deductible	50%, after deductible	80%, after deductible	50%, after deductible	90%, after deductible	70%, after deductible

For more information visit:
<https://idimages.eebenefits.site/>

When you enroll in a medical plan, you automatically receive prescription drug benefits. Please see the chart below for an overview of the Cigna prescription drug benefits.

Prescription Drug Benefits			
Benefit	OAP \$7,500 (Base)	OAP \$2,500 (Buy-up)	HDHP \$3,750
Retail Pharmacy (per 30-day supply)			
• Generic	\$25 Copay	\$10 Copay	\$10 Copay (AD)
• Brand	\$60 Copay	\$50 Copay	\$50 Copay (AD)
• Non-Preferred	\$95 Copay	\$90 Copay	\$90 Copay (AD)
• Specialty	30%	30%	30% AD
Retail and Home Delivery Pharmacy (per 90-day supply)			
• Generic	\$75 Copay	\$25 Copay	\$25 Copay (AD)
• Brand	\$180 Copay	\$125 Copay	\$125 Copay (AD)
• Non-Preferred	\$285 Copay	\$225 Copay	\$225 Copay (AD)

*AD = After Deductible



VIRTUAL SERVICES

Know before you go.

Get the right care, at the right time, in the right place.



Lower Cost and time Greater				
	Virtual urgent care ¹	Local provider	Urgent care center	Emergency room
	On-demand 24/7 or schedule a time that works for you to receive care for minor medical illnesses and injuries. Prescriptions may be available if necessary. Access virtual care on the myCigna® App or myCigna.com® , or by calling MDLIVE® at 888.726.3171 . ²	Schedule an in-person appointment with a local health care provider to treat common ailments and manage care for all health conditions. Find an in-network provider on myCigna.com .	For medical conditions that aren't life threatening. Find an in-network urgent care center on myCigna.com . ²	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life threatening, call 911 or go to the nearest ER.
Ages	All ages. Parent/guardian must accompany minors.	All ages. May vary by provider/service.	All ages. May vary by location. Confirm restrictions for infants as many have age limits.	All ages.
Conditions treated ³	• Colds and flu • Rashes • Sore throats • Pink eye • Ear pain⁴ • Fever⁴ • Allergies • Acne • Urinary tract infections (UTIs)⁴ and more	• General health issues • Preventive care • Routine checkup • Vaccines and screenings • Acute sickness • Questions regarding health	• Fever and flu symptoms • Joint pain, sprains and cuts • Minor respiratory symptoms • Stomach pains • STDs • UTIs	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose
Cost and time	• More affordable than in-person and urgent care or ER visit • Connect with a doctor in minutes • No need to leave work or home with visits available by phone or video	• May charge copay/coinsurance and/or deductible • Usually need appointment • Short wait times	• Lower cost than emergency room (ER) • No appointment needed • Waiting times vary • Available most days of the week • Often have extended hours • In-person treatment	• Most expensive • Available 24/7/365 • No appointment needed • Waiting times vary • In-person treatment



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VIRTUAL SERVICES

Virtual care from MDLIVE

On average, virtual urgent care saves \$114 per visit.⁵ Virtual care visits are convenient and easy, whether you choose on-demand care or schedule an appointment. And you can select an appointment in English or Spanish. Visit **myCigna** and click "Talk to a Doctor" or call MDLIVE at **888.726.3171** when you need virtual care.

Health Information Line

Not sure which option is best for you? The Cigna HealthcareSM no-cost Health Information Line puts you in touch with a personal health advocate.⁶ These trained nurses are here to answer your health questions and help you make the best choice for your needs. Log in to the **myCigna App** or **myCigna.com** to chat with a health advocate today.

Know before you go. We can help.

Conveniently search for virtual or in-person care, 24/7 through **myCigna**.

Visit **myCigna.com** or download the **myCigna App**.⁷



Here's How It Works

Accidental Injury Insurance provides benefits to help cover unexpected costs associated with a non-work-related accident. If a covered injury occurs, this plan pays benefits regardless of any other insurance coverages. Mutual of Omaha will send a check for covered injuries; you decide the best way to spend it.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Examples of Covered Accidents and Injuries

- Broken bones and burns
- Torn ligaments, joint dislocations and ruptured discs
- Eye injuries
- Concussion



For more information visit:
<https://idimages.eebenefits.site/>

An HSA is a tax-sheltered bank account that you own for the purpose of paying eligible health expenses for you and/or your eligible dependents for current or future healthcare expenses. The account is flexible, so you decide how much to contribute and when to use the funds to pay for your eligible health care expenses such as deductibles, copays, prescriptions, dental and vision expenses. As long as the funds are used for qualified healthcare expenses, they are not subject to federal income tax. Optum is our HSA administrator.

How an HSA works

- Contributions are not taxed, and you can invest the balance in a variety of options.
- Your account (including interest and investment earnings) grows tax-free — and as long as the funds are used to pay for qualified medical expenses, they are spent tax-free.
- Use the money in your HSA to pay for qualified medical expenses. You always have the option of using your own funds and letting your HSA continue to grow for future use.
- Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.
- Unlike a Flexible Spending Account (FSA), there's no "use it or lose it" rule — the money in your account will automatically roll over year after year. And since it's an individual account, the balance is yours even if you change health plans or leave the Company.



You may use your HSA funds to pay for qualified dependent's healthcare expenses even if you do not cover them on your medical plan. There are certain IRS restrictions on HSA participation upon other family members benefit plan enrollment through I.D. Images or their own employer's health plan as well as receipt of VA benefits, Medicare or Tricare medical benefits. Consult a tax advisor for more information or visit the IRS website at www.irs.gov and select Publication 969, "Health Savings Accounts and Other Tax Favored Health Plans."

HSA Eligibility

You must meet the following requirements to be an "eligible individual" who qualifies for an HSA:

- You must be enrolled in the medical HDHP plan.
- You are not currently enrolled in a Health Care FSA.
- You may not be covered by any other non-high deductible health plan that covers the same expenses as the HDHP.
- You are not claimed by any other person as a tax dependent.
- You are not covered by Medicare (Medicare eligibility does not disqualify you).



HSA contributions may not exceed the annual maximum

2025 HSA Limits		
	2025 IRS Limit	Your Maximum Contribution*
Individual	\$4,300	\$3,800
Family	\$8,550	\$8,050
Age 55+	Contribute an additional \$1,000	



It is your responsibility to understand your rights and requirements under the tax code for HSA participation, contributions and withdrawals. I.D. Images assumes no responsibility in the determination of your eligibility for contribution to an HSA under the IRS regulations.

I.D. Images will not assume any tax responsibility due to ineligibility or inappropriate use of an HSA.

Basic Life and AD&D Insurance

I.D. Images of America, Inc. provides full-time employees with both life and accidental death and dismemberment (AD&D) insurance. Hourly employees receive a benefit in the amount of \$25,000. and Salaried employees receive a benefit 1x annual base earnings Mutual of Omaha.

Please be sure to update your beneficiary information on Paycom.

Reductions Due to Age

Basic and Voluntary Life elections will reduce for employees and spouses to 65% at age 65, and 50% at age 70. The reduced benefit amount takes effect on the day you become insured if you are that age at the time of the election, or on the date you attain age 65 or 70.

For your coverage to become effective, you must be actively at work during the enrollment period and on the effective date of the plan. If you apply for an amount that requires satisfactory evidence of insurability, you must be actively at work on the date of approval. Refer to the plan booklet for details.



For more information visit:
<https://idimages.eebenefits.site/>

Short-Term Disability (STD) and Long-Term Disability (LTD)

I.D. Images provides all full-time employees disability insurance as income protection in the event you are unable to work as a result of an illness or injury (outside of work). I.D. Images provides this coverage at no cost to you.

Disability Coverage		
Benefit Coverages	Employer Paid STD	Employer paid LTD
Elimination Period	7 days – Accident / Injury 7 days – Sickness	90 days
Benefit Percentage	60%	60%
Maximum Benefit	\$500	\$5,000
Maximum Period of Payment	13 weeks	Social Security Normal Retirement Age



I.D. Images offers a comprehensive Employee Assistance Plan (EAP) through Mutual of Omaha, at no cost to you. The Enhanced EAP Services offers professional, confidential services to help you and your loved ones improve your quality of life.

Unlimited 24/7 Assistance

You and your family can access the following services any time — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning
- Substance abuse and addiction

Online Resources

Enhanced EAP offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit mutualofomaha.com/eap You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

Take Advantage of the Enhanced EAP Services

For more information, visit mutualofomaha.com/eap, or call 800-316-2796.



Health care lingo can be confusing. Here are some terms you might need to know:

Claim: A request for payment that you or your health care provider submits to your health insurance company after you receive services.

Coinsurance: Your share of the costs for a covered health care service, calculated as a percentage. You pay coinsurance plus any deductibles you owe. For example, say your health plan's allowed amount for an office visit is \$100 and you've met your deductible. Your coinsurance payment of 20% would be \$20. Your health plan pays the rest of the allowed amount.

Copay: The fixed amount (for example, \$25) you pay for a covered health care service, usually when you receive the service. The amount can vary, depending on the provider and the type of health care service. Members do not need to satisfy the deductible before copays apply.

Deductible: The amount you pay for services received before your health plan begins to pay. For example, if your deductible is \$1,000, your health plan will not pay for covered services until you've paid \$1,000 toward your covered health care expenses. After that, your health plan will pay for all covered services in that benefit year.

Explanation of Benefits (EOB): An EOB is a statement from your health insurance plan describing what costs it will cover for medical care, and any amounts that you are responsible for.

Elimination Period: The period of time that you must be considered disabled due to an injury or an illness before disability claim benefits will be paid.

In-Network: The facilities, providers and suppliers your health plan contracts with to provide health care services. You will typically pay less for services received in network versus out of network.

Out of Network: The facilities, providers and suppliers that do not contract with your health plan. Your health plan will typically pay less for services received at providers that do not participate in the carrier network. Out of network providers may be subject to balance billing.

Out of pocket: Your costs for medical care expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus costs for services that aren't covered.

Subscriber: The person who enrolls in a health plan. There is only one subscriber per health plan. The subscriber can add eligible dependents to a family health plan.

Preauthorization/prior authorization: A decision verifying that a service, prescription drug or type of treatment is medically necessary. Certain services and medications require preauthorization before you receive them, except in an emergency.

Premium: The amount you pay for your health plan, per pay period.

Primary care physician (PCP): The main doctor and primary contact for your health care services.

Specialist: A doctor or health care professional who focuses on a specific area of medicine. For example, orthopedic surgeons, dermatologists and cardiologists are specialists.

Telehealth: Allows a patient to connect with a health care provider with virtual visits through an electronic device such as a smartphone or computer. Licensed telehealth providers offer non-emergency consultations for a variety of conditions and can prescribe medication, when appropriate.

Carrier Customer Service

Benefits Plan	Carrier	Phone Number	Website
Medical & Rx	Cigna	800-442-7742	www.mycigna.com
Dental	Cigna	800-442-7742	www.mycigna.com
Vision	Cigna	800-442-7742	www.mycigna.com
Health Savings Account (HSA)	Optum	800-532-3327	www.optum.com
Life and AD&D Insurance	Mutual of Omaha	800-423-2765	www.mutualofomaha.com
Short & Long-Term Disability	Mutual of Omaha	800-423-2765	www.mutualofomaha.com
Accident Insurance	Mutual of Omaha	800-997-1654	www.mutualofomaha.com
Medicare	MyBenefit Advisor	856-334-4456	karencoia@emersonreid.com
General Benefit Questions	Benefit Resource Center	855-874-0835	BRCSouth@usi.com

For Additional Resources and Notices please Visit Our Benefits Site: <https://idimages.eebenefits.site/>

I.D. Images

Important Legal Notices



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page xx for more details.



***IMPORTANT NOTICE:** This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

- ☐ Surest F9000 (base): \$0 Deductible; 100% Coinsurance
- ☐ Surest D6500 (Buy-up): \$0 Deductible; 100% Coinsurance
- ☐ HDHP \$3,750 w/ HSA: \$3,750 Deductible; 90% Coinsurance

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid

coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- ☐ coverage is lost under Medicaid or a State CHIP program; or
- ☐ you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- ② Examine, without charge, at the Plan Administrator’s office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- ② Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- ② Receive a summary of the Plan’s annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you

have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Maria Davis

2991 Interstate Parkway

Brunswick, Ohio United States 44212

330-5588064

mdavis@idimages.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- ☐ Get a copy of your health and claims records
- ☐ Correct your health and claims records
- ☐ Request confidential communication
- ☐ Ask us to limit the information we share
- ☐ Get a list of those with whom we've shared your information
- ☐ Get a copy of this privacy notice
- ☐ Choose someone to act for you
- ☐ File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- ☐ Answer coverage questions from your family and friends
- ☐ Provide disaster relief
- ☐ Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- ☐ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- ☐ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective June 5th 2025
- Maria Davis, mdavis@idimages.com

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from I.D. Images About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011**

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 I.D. Images coverage will [or will not] be affected.

If you do decide to join a Medicare drug plan and drop your current I.D. Images coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with I.D. Images 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 I.D. Images changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About 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:

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

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

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).

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page xx for more details.

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 January 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.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
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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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: 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/off/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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: ChildrensHealthInsuranceProgram(CHIP).pa.gov	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)

CHIP Phone: 1-800-986-KIDS (5437)	
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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://dhhr.wv.gov/bms/ http://mywvhipp.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 January 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

Paperwork Reduction Act Statement

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

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



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.

¹Indexed 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

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 I.D. Images		4. Employer Identification Number (EIN) 26-0185040	
5. Employer address 1120 West 130 th St		6. Employer phone number 330-558-8064	
7. City Brunswick		8. State OH	9. ZIP code 44212
10. Who can we contact about employee health coverage at this job? Maria Davis			
11. Phone number (if different from above)		12. Email address mdavis@idimages.com	

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:

Full-time working at least 30 hours per week

☐ Some employees. Eligible employees are:

• With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse and children up 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.

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

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

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

