Required Information Form

Please supply the following required information:

Health Plan Name: City of Menasha Health Plan

Plan Sponsor Name: City of Menasha

Address: 140 Main Street

City / State / Zip: Menasha, WI 54952

Effective Date of Coverage: 1/1/16

Ending Date of Coverage: 12/31/16

Date of Notice: October 15, 2015

Plan #: 76-440178

EIN #: 39-6005525

If Grandfathered, select if adult dependent children Select One **be eligible.**

Contact Name or Title: Peggy Steeno, Director of Admin Services

Contact Phone: 920-967-3631

Contact E-Mail Address: psteeno@ci.menasha.wi.us

Updated 8/11/15

Model Notice Kit

[2015]

While every effort has been made to provide a complete summary and sampling of required notices, the enclosed information should not be considered exhaustive.

From Your Employer

Algunas noticias seleccionadas son disponibles en español. Por favor, refiere al sitio del web del Departamento do Trabajo en www.dol.gov.

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIP)

Effective April 1, 2009, employees and dependents that are eligible for healthcare coverage under the health plan, but are not enrolled, will be permitted to enroll in the plan if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP.

Individuals must request coverage under the plan within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

CHIPRA allows states to offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If this State offers a premium assistance subsidy, you will be notified in writing of the potential opportunities available for premium assistance in the plan year after model notices are issued.

Medicaid and the Children's Health Insurance Program (CHIP)

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not 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, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free **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, 2015. You should contact your State for further information on eligibility:

ALABAMA – Medicaid **Website: http://www.myalhipp.com** **Phone: 1-855-692-5447**	**GEORGIA – Medicaid** **Website: http://dch.georgia.gov/** ***Click on 'Programs', then 'Medicaid', then 'Health Insurance Premium Payment (HIPP)'*** **Phone: 1-404-656-4507**
ALASKA – Medicaid **Website: http://health.hss.state.ak.us/dpa/programs/medicaid/** **Phone (Outside of Anchorage): 1-888-318-8890** **Phone (Anchorage): 907-269-6529**	**INDIANA – Medicaid** **Website: http://www.in.gov/fssa** **Phone: 1-800-889-9949**
COLORADO – Medicaid **Medicaid Website: http://www.colorado.gov/hcpf** **Medicaid Phone: 1-800-221-3943**	**IOWA – Medicaid** **Website: http://www.dhs.state.ia.us/hipp/** **Phone: 1-888-346-9562**
FLORIDA – Medicaid **Website: https://www.flmedicaidtplrecovery.com/** **Phone: 1-877-357-3268**	**KANSAS – Medicaid** **Website: http://www.kdheks.gov/hcf/** **Phone: 1-800-792-4884**

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KENTUCKY – Medicaid **Website: http://chfs.ky.gov/dms/default.htm** **Phone: 1-800-635-2570**	**NEW HAMPSHIRE – Medicaid** **Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf** **Phone: 1-603-271-5218**
LOUISIANA – Medicaid **Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331** **Phone: 1-888-695-2447**	**NEW JERSEY – Medicaid and CHIP** **Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** **Medicaid Phone: 1-609-631-2392** **CHIP Website: http://www.njfamilycare.org/index.html** **CHIP Phone: 1-800-701-0710**
MAINE – Medicaid **Website:** **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** **Phone: 1-800-977-6740** **TTY: 1-800-977-6741**	**NEW YORK – Medicaid** **Website: http://www.nyhealth.gov/health_care/medicaid/** **Phone: 1-800-541-2831**
MASSACHUSETTS – Medicaid and CHIP **Website: http://www.mass.gov/MassHealth** **Phone: 1-800-462-1120**	**NORTH CAROLINA – Medicaid** **Website: http://www.ncdhhs.gov/dma** **Phone: 919-855-4100**
MINNESOTA – Medicaid **Website: http://www.dhs.state.mn.us/id_006254** ***Click on 'Health Care', then 'Medical Assistance'*** **Phone: 1-800-657-3739**	**NORTH DAKOTA – Medicaid** **Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/** **Phone: 1-800-755-2604**
MISSOURI – Medicaid **Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** **Phone: 573-751-2005**	**OKLAHOMA – Medicaid and CHIP** **Website: http://www.insureoklahoma.org** **Phone: 1-888-365-3742**
MONTANA – Medicaid **Website: http://medicaid.mt.gov/member** **Telephone: 1-800-694-3084**	**OREGON – Medicaid** **Website: http://www.oregonhealthykids.gov** **Website: http://www.hijossaludablesoregon.gov** **Phone: 1-800-699-9075**
NEBRASKA – Medicaid **Website: www.accessnebraska.ne.gov** **Phone: 1-855-632-7633**	**PENNSYLVANIA – Medicaid** **Website: http://www.dhs.state.pa.us/hipp** **Phone: 1-800-692-7462**
NEVADA – Medicaid **Medicaid Website: http://dwss.nv.gov/** **Medicaid Phone: 1-800-992-0900**	**RHODE ISLAND – Medicaid** **Website: http://www.eohhs.ri.gov/** **Phone: 401-462-5300**

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SOUTH CAROLINA – Medicaid **Website: http://www.scdhhs.gov** **Phone: 1-888-549-0820**	**VIRGINIA – Medicaid and CHIP** **Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm** **Medicaid Phone: 1-800-432-5924** **CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm** **CHIP Phone: 1-855-242-8282**
SOUTH DAKOTA – Medicaid **Website: http://www.dss.sd.gov** **Phone: 1-888-828-0059**	**WASHINGTON – Medicaid** **Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx** **Phone: 1-800-562-3022 ext. 15473**
TEXAS – Medicaid **Website: http://www.gethipptexas.org/** **Phone: 1-800-440-0493**	**WEST VIRGINIA – Medicaid** **Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx** **Phone: 1-877-598-5820 (HMS Third Party Liability)**
UTAH – Medicaid and CHIP **Medicaid Website: http://health.utah.gov/medicaid** **CHIP Website: http://health.utah.gov/chip** **Phone: 1-866-435-7414**	**WISCONSIN – Medicaid** **Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** **Phone: 1-800-362-3002**
VERMONT– Medicaid **Website: http://www.greenmountaincare.org/** **Telephone: 1-800-250-8427**	**WYOMING – Medicaid** **Website: https://wyequalitycare.acs-inc.com/** **Telephone: 307-777-7531**

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor **Employee Benefits Security Administration** **www.dol.gov/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**

OMB Control Number 1210-0137 (expires 10/31/2016)

COBRA – General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

A Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, created the right to COBRA continuation coverage (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. See plan administrator for details.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the plan as a “dependent child.”

If the Plan provides retiree health coverage:

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Menasha and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, if Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days. You must provide this notice to: Peggy Steeno, Director of Admin Services

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. This 18-month period of COBRA continuation coverage can be extended in two ways.

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation

coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information:	City of Menasha
Name of Group Health Plan:	City of Menasha Health Plan
Contact Name (or position):	Peggy Steeno, Director of Admin Services
Address:	140 Main Street
City, State Zip:	Menasha, WI 54952
Phone Number:	920-967-3631

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates because of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Non-Grandfathered Plan – Important Information

Plan Status

Your plan is classified as **Non-Grandfathered.**

Dependent Coverage to Age 26

For health plans beginning on or after September 23, 2010, young adults are allowed to stay on their parent's employer's health plan until they turn 26 years old. Before the health care law, insurance companies could remove enrolled children usually at age 19, sometimes older for full-time students. Now, most health plans that cover children must make coverage available to children up to age 26. By allowing children to stay on a parent's plan, the law makes it easier and more affordable for young adults to get health insurance coverage.

Your children can join or remain on your plan even if they are:

- Married
- Not living with you
- Attending school
- Not financially dependent on you
- Eligible to enroll in their employer's plan

Non-Grandfathered Health Plans – Patient Protection Information

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

City of Menasha generally requires or allows the designation of a primary care provider. See plan administrator for details. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Peggy Steeno, Director of Admin Services at 920-967-3631.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

You do not need prior authorization from City of Menasha or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approval treatment plan, or procedures for making referrals. For a list of participating health care professions who specialize in obstetrics or gynecology, contact Peggy Steeno, Director of Admin Services at 920-967-3631.

Preventative Care:

Non-Grandfathered Plans required to cover certain preventive services without any cost-sharing for the enrollee when delivered by in-network providers. Reference the insurance carrier for specific details.

New Health Insurance Marketplace Coverage
Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact City of Menasha .

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

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

HIPAA – Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS IS A REMINDER OF THE PRIVACY NOTICE YOU RECEIVED BY APRIL 18, 2010. *PLEASE REVIEW IT CAREFULLY.*

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the City of Menasha Health Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). This notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations of 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule. The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/16. [Note: the effective date may not be earlier than the date on which the privacy notice is printed or otherwise published.]

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with Federal privacy laws and respect your right to privacy. City of Menasha requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision or health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information:

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health related benefits or services that may be of interest to you, response to a court order, or provide information to further public health activities (e.g. preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale or acquisition. We ill also disclose health information about you when required by law, for example, in order to prevent serious harm to your or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities knows as Business Associates that provide services to or perform functions on behalf of the plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of City of Menasha for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronics health record, you may be able to receive the information in electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will note include disclosures that were made **(1)** for purposes of treatment, payment or health care operations; **(2)** to you; **(3)** pursuant to our authorization; **(4)** to our friends or family in your presence or because of an emergency; **(5)** for national security purposes; or **(6)** incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. WE will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with Federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibility. We are requested by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice. We may change our policies at any time. In the event that we made a significant change in our policies, we will provide you with a revised copy of this notice. YOU can also request a copy of our notice at any time. For more information about our privacy practices, contact the following:

Individual's Name or Person's Title:	Peggy Steeno, Director of Admin Services
Organization's Name:	City of Menasha
Street Address:	140 Main Street
City / State / Zip:	Menasha, WI 54952
Phone Number:	920-967-3631
e-Mail Address:	psteeno@ci.menasha.wi.us

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services – Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

HIPAA – Portability Rights and Special Enrollment Rights

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.
For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at **1-866-444-3272** (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at **1-800-633-4227** (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: **http://www.dol.gov/ebsa**, the DOL's interactive web pages – Health Elaws or **http://www.cms.hhs.gov/HealthInsReformforConsume**.

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent because of a 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, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name:	Peggy Steeno, Director of Admin Services
Street Address:	140 Main Street
City / State / Zip:	Menasha, WI 54952
Telephone:	920-967-3631

Note: If you and your eligible dependents enroll during a special enrollment period, as described above, you are not considered a late enrollee. Therefore, your group health plan may not require you to serve a pre-existing condition waiting period of more than 12 months. Any preexisting condition waiting period will be reduced by time served in a qualified plan.

Medicare Part D – Individual Creditable Coverage Disclosure Notice Language

OMB 0938-0990

Important Notice from City of Menasha 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 City of Menasha and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including costs of covered drugs, 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.

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. City of Menasha has determined that the prescription drug coverage offered by the City of Menasha Health Plan, on average for all plan participants, expects to pay out as much as standard Medicare prescription drug coverage pays and 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 through December 7th.

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

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

If you decide to join a Medicare drug plan, your current City of Menasha coverage will or will not be affected. See plan administrator for details. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/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.

If you do decide to join a Medicare drug plan and drop your current City of Menasha coverage, be aware that you and your dependents will or will not be able to get this coverage back. See your plan administrator for details.

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 City of Menasha and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you might 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 will 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 City of Menasha changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

Additional detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. Medicare drug plans may also contact you directly.

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).

Date:	October 15, 2015
Plan Sponsor Name:	City of Menasha
Address:	140 Main Street
City / State / Zip:	Menasha, WI 54952
Contact Name:	Peggy Steeno, Director of Admin Services
Contact Phone:	920-967-3631

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.

Michelle's Law

For plan years starting on or after **October 9, 2009**, the law prohibits a group health plan from terminating a college student's health coverage on the basis of the child taking a medically necessary leave of absence, as certified by a physician, from school or changing to a part-time status due to a medically necessary condition. For plans on a calendar-year basis, this law becomes effective on **January 1, 2010**.

To take advantage of the extension, the child must have been enrolled in the group health plan on the basis of being a student at a post-secondary educational institution immediately before the first day of the leave.

Health plans are required to keep the dependent's coverage active during a medically necessary leave of absence until:

- One year after the first date of the medically necessary leave of absence, or
- The date coverage would otherwise terminate under the plan

The student on leave is entitled to the same benefits as if they had not taken a leave except if there are changes in: coverage, insurance carrier, and/or fully insured to self-funded or vice versa.

Physician's Certification and Notice: The group health plan must receive written certification by the child's treating physician stating the child is suffering from a serious illness or injury, and the leave (or change of enrollment) is medically necessary.

Newborns’ and Mothers’ Health Protection Act of 1996

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 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 carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours).

YOUR RIGHTS UNDER USERRA
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008

Women’s Health and Cancer Rights Act of 1998

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 has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.