The sample language included in the notices is not intended to express a legal opinion. It is only visual information used to provide a basic understanding of the materials and presentation. If you need specific advice, please seek a legal professional who is licensed or knowledgeable in that area.

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Additionally, please note that the enclosed information is Federal-specific. State mandates may also apply.

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

Required Information Form

Please supply the following required information:

Health Plan Name:

Plan Sponsor Name: City of Menasha

Address: 140 Main Street

City / State / Zip: Menasha WI 54952

Effective Date of Coverage:

Ending Date of Coverage:

Date of Notice: 01/15/2014

Plan #:

EIN #:

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

Contact Name or Title: Michael Brunn

Contact Phone: 920 967-3604

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

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices

The following chart is an overview of some basic reporting and disclosure requirements that apply to group health plans and/or employers. Note that not all reporting and disclosure requirements are reflected in this chart. For complete information on the necessary reporting and disclosure requirements, users of this chart should refer to the specific Federal law at issue.

Law	Governs	Notice Requirement	Summary
CHIP / CHIPRA	Notice requirement applies to employers that maintain group health plans in states that provide premium assistance subsidies under a Medicaid plan or CHIP.	**Annual Employer CHIP Notice notifying employees of potential State opportunities for premium assistance.** First notice must be sent by the first day of the first plan year beginning after **February 4, 2010,** or **May 1, 2010**, whichever is later. For employers with calendar year plans, the notice must be sent by **January 1, 2011.**	States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If an employer's group health plan covers residents in a State that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in the State. Employers may use the model notice provided by the DOL as a national notice to meet their obligations under CHIPRA. The notice may be provided in writing by first-class mail or electronically if DOL electronic disclosure requirement are satisfied. For a copy of the model notice, see **www.dol.gov/ebsa/pdf/chipmodelnotice.pdf**
COBRA	Employers that had 20 or more employees on more than 50% of the typical business days during the previous calendar year. Government and church plans are exempt.	**Initial/General COBRA notice** – generally within 90 days of when group health plan coverage begins.	Notice to covered employees and covered spouses of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.
		Notice to Plan Administrator – Employer must notify plan administrator within 30 days of a) qualifying event or b) the date coverage would be lost because of the qualifying event, whichever is later.	Notice of qualifying event must be sent to plan administrator when employer is not plan administrator (e.g., employer has contracted with a third party to administer COBRA.)
		Cobra election notice – generally within 14 days after being notified by the employer or qualified beneficiary of the qualifying event (or 44 days after qualifying event if employer is also plan administrator).	Notice to qualified beneficiaries of their right to elect COBRA coverage upon occurrence of qualifying event. Qualified beneficiaries may be covered employees, covered spouses and dependent children.
		Notice of unavailability of COBRA – plan administrator must provide this notice generally within 14 days after being notified by the individual of qualifying event (or 44 days after qualifying event if employer is also plan administrator).	Plan administrator must send a notice that an individual is not entitled to COBRA coverage to those individuals who provide notice to the plan administrator of a qualifying event whom the plan administrator determines are not eligible for COBRA coverage.
		Notice of early termination of COBRA coverage – as soon as practicable following the plan administrator's determination that coverage will terminate.	Notice to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of the coverage, reason for early termination, date of termination and any rights that qualified beneficiary may have to elect alternative group or individual coverage, such as a conversion right. May be sent with HIPAA certificate of creditable coverage.
		Notice of insufficient payment – Plan must provide reasonable period of time to cure deficiency before terminating COBRA (e.g., 30 day grace period).	Notice to qualified beneficiary that payment for COBRA was not significantly less than the correct amount before coverage is terminated for nonpayment. A payment is not significantly less than the amount required if the deficiency is no greater than the lesser of $50.00 or 10 percent of the amount the plan requires to be paid.

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices *continued*

Law	Governs	Notice Requirement	Summary
		Premium change notice – at least one month prior to effective date.	COBRA does not explicitly require advance notice of a premium increase. However, COBRA regulations provide that if a COBRA premium payment is short by an amount that is insignificant, the qualified beneficiary must be provided notice of such underpayment and a reasonable amount of time to make the payment difference. Also, COBRA requires equal coverage and, to some extent, equal treatment between COBRA qualified beneficiaries and similarly situated non-COBRA beneficiaries. The DOL has stated that continuation coverage should not be terminated for insufficient payment if COBRA qualified beneficiaries are not provided a reasonable advance notice of increased premiums and a reasonable opportunity to pay the increased premium.
ERISA	ERISA employee welfare benefit plans, unless exempted.	**Summary plan descriptions** – Automatically to participants within 90 days of becoming covered by the plan and to pension plan beneficiaries within 90 days after first receiving benefits (though plan has 120 days after becoming subject to ERISA to distribute SPD.) Updated SPD must be furnished every five years if changes made to SPD. Otherwise, must furnish every 10 years. *	SPD is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan. Must accurately reflect the plan's contents as of the date not earlier than 120 days prior to the date the SPD is disclosed. *
		Summary of material modification – automatically to participants and pension plan beneficiaries receiving benefits; not later than 210 days after the end of the plan year in which the change is adopted*; if benefits or services are materially reduced, participants must be provided notice within 60 days from adoption; or, where participants receive such information from the plan administrator at regular intervals of not more than 90 days, notice of materially reduced benefits or services must be provided within 90 days.	Describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.*
		Plan documents – copies must be furnished no later than 30 days after a written request. Plan administrator must make copies available at its principal office and certain other locations as specified in regulations.	The plan administrator must furnish copies of certain documents upon written request by a participant and/or beneficiary and must have copies available for examination. The documents include the latest updated SPD, latest Form 5500, trust agreement and other instruments under which the plan is established or operated.
		Form 5500 – generally must be filed by the last day of the seventh month following the end of the plan year, unless an extension has been granted. For calendar year plans, the deadline is normally July 31st of the following year.	Form 5500 filing requirements vary according to the type of filer (i.e., small plans, large plans and direct filing entities). Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options. The DOL internet site at **http://www.dol.gov/EBSA/5500MAIN.html** and then latest Form 5500 instructions provide information on who is required to file and detailed information on filing.

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices *continued*

Law	Governs	Notice Requirement	Summary
		Summary annual report – automatically to participants and pension plan beneficiaries receiving benefits within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension.)	Narrative summary of the Form 5500 and state of right to receive annual report. Model notices are found in 29 CFR 2520.104b-10(d).
Family and Medical Leave Act (Federal FMLA)	Covered employers (private sector employers with 50 or more employees in 20 or more workweeks in current or preceding calendar year, as well as all public agencies and local educational agencies).	**Post notice** in a location available to both employees and applicants. **Written guidance**, if it exists. **Written guidance**, upon employee notice of need for FMLA leave.	All employers are required to post a notice explaining the FMLA, including the family military leave amendments, regardless of whether they have eligible employees. If written guidance regarding employee benefits or leave rights exists, such as in an employee handbook, then FMLA information regarding entitlements and obligations must be included in it as well. Written guidance must be provided to an employee upon the employee's notice to the employer of the need for FMLA leave (i.e., eligibility notice, and rights and responsibilities notice). The employer must detail the specific expectations and obligations of the employee, and explain the consequences of the failure to meet these obligations. After the employer has sufficient information, it must provide a designation notice informing the employee whether the leave is designated as FMLA leave. The DOL has issued optional forms which may be used to satisfy these notice requirements. The can be accessed at: **http://www.dol.gov/whd/fmla/2013rule/**
Grandfathered Health Plan Notice	All Grandfathered Medical Plans	**Notice of Grandfathered Plan Status** – Must be provided to plan members annually.	As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act.
HIPAA – Privacy and Security	**Covered Entities:** Group health plans, health care clearing – houses, health care providers that transmit any health information electronically, and enrolled sponsors of Medicare prescription drug discount card, unless exception applies.	**Notice of Privacy Practices** – the plan administrator of covered entities must comply by April 14, 2004 and every 3 years thereafter for large plans; small plans have until April 14, 2004 and every 3 years thereafter; must also comply at enrollment and within 60 days of a material revision to the notice.	HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.
	Business Associates: service providers to Covered Entities that use protected health information (PHI).	**Notice of Breach of Unsecured PHI** – HIPAA covered entities and their business associates must provide notification following a breach of unsecured PHI without unreasonable delay and in no case later than 60 days following the discovery of a breach.	Following a breach of unsecured PHI, covered entities must provide notification of the breach to affected individuals, the Department of Health and Human Services and, in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices *continued*

Law	Governs	Notice Requirement	Summary
HIPAA – Portability and Special Enrollment Rights	Group health plans and issuers of group health plan insurance coverage, unless exception applies.	**Certificate of Creditable Coverage** – Automatically upon losing group health plan coverage, becoming eligible for COBRA coverage, and when COBRA coverage ceases. A certificate may be requested free of charge any time prior to losing coverage and within 24 months of losing coverage.*	Notice from employee's former group health plan to participants and beneficiaries who lose coverage, documenting prior group health plan creditable coverage and length of time covered.
		General notice of preexisting condition exclusion – must be provided as part of any written application material distributed for enrollment. If the plan or issuer does not distribute such materials, by the earliest date following a request for enrollment that a plan or issuer, acting in a reasonable and prompt fashion, can provide the notice. *	Notice to participants describing a group health plan's preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period.
		Individual notice of period of pre-existing condition exclusion – as soon as possible following the determination of creditable coverage.*	Notice to participants and beneficiaries, who demonstrate creditable coverage that is not enough to completely offset the preexisting condition exclusion, that a specific preexisting condition exclusion period applies to an individual upon consideration of creditable coverage evidence and an explanation of appeal procedures if the individual disputes the plan's determination.
		Notice of special enrollment rights – at or before the time an employee is initially offered the opportunity to enroll in the group health plan. *	Notice to employees eligible to enroll in a group health plan describing the group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of the loss of coverage under Medicaid plan or CHIP, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.
Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan.	At a minimum, **Disclosure Notices for creditable or non-creditable coverage** must be provided by the plan at the following times: 1) Prior to the Medicare Part D Annual Coordinated Election Period – beginning October 15th through December 7th of each year; 2) Prior to an individual's Initial Enrollment Period for Part D; 3) Prior to the effective date of coverage for any Medicare eligible individual that joins the plan; 4) Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and 5) Upon a beneficiary's request.	**Group health plans** – or entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals – must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices *continued*

Law	Governs	Notice Requirement	Summary
		Disclosure to CMS made an annual basis (60 days after the beginning of the plan year) and upon any change that affects creditable coverage status (within 30 days of the change).	Employers must disclose the Centers for Medicare and Medicaid Serves (CMS) whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Notice form on the CMS Creditable Coverage Disclosure Web Page at **https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html** unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.
Medicare Part D – Retiree Drug Subsidy	Employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so.	At least 90 days before the beginning of each plan year, **plan sponsors must apply for retiree drug subsidy,** unless CMS approves request for extension. Medicare beneficiaries must be notified that plan's coverage is creditable.	An employer who wishes to sponsor a prescription drug plan with retiree prescription drug coverage that is at least as good as Part D coverage may apply for the retiree drug subsidy, which is exempt from Federal income tax. The subsidy is available to employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so. Each Plan Sponsor that seeks the retiree drug subsidy must electronically complete the application through the RDS Center at **http://rds.cms.hhs.gov**.
Mental Health Parity Act (MHPA)/Mental Health Parity and Addiction Equity Act (MHPAEA) **MHPA – EFFECTIVE FOR PLAN YEARS BEGINNING BEFORE OCTOBER 4, 2009** **MHPAEA – EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER OCTOBER 4, 2009**	Group health plans (of employers with over 50 employees) offering mental health and substance use disorder benefits. Exemption available for group health plans that can demonstrate a certain cost increase.	**MHPA** – 30 days before the exemption becomes effective – group health plans covered under ERISA claiming the increased cost exemption must **notify the DOL, plan participants and beneficiaries.** Upon written request. **MHPAEA** – group health plans claiming the increased cost exemption must **promptly notify the appropriate Federal and State agencies, plan participants and beneficiaries.** Upon request.	**MHPA** – The mental health parity requirements do not have to be met by any group health plan whose costs increase 1% or more due to the application of the MHPA's requirements. The increased cost exemption must be based on actual claims data, not on an increase in insurance premiums. The plan must implement the provisions of the MHPA for at least 6 months and the calculation of the 1% cost exemption must be based on at least 6 months of actual claims data with parity in place. **Upon written request** – A summary of the aggregate data and the computation supporting the increased cost exemption must be made available to plan participants and beneficiaries free of charge upon written request. **MHPAEA** – The cost exemption will apply to a group health plan if its cost increase exceeds 2% in the first plan year and 1% in each subsequent year. Cost-increase determinations must be made and certified in a written actuarial report. The plan must comply with the parity requirements for the first 6 months of the plan year involved. The written report and underlying documentation must be maintained for 6 years following the notification to elect the cost exemption. A group health plan or health insurance issuer shall promptly notify the Secretaries of the DOL, HHS and the Treasury, the appropriate State agencies, and participants and beneficiaries in the plan of such election. A notification to the Secretaries shall include: • A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption by such plan (or coverage);

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices *continued*

Law	Governs	Notice Requirement	Summary
			• For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and • For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to the mental health and substance use disorder benefits under the plan. **Upon request** – The plan administrator or health insurance issuer must provide the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits, upon request by a current or potential participant, beneficiary or contracting provider. The plan administrator or health insurance issuer must also make available upon request, or as otherwise required, the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of the participant or beneficiary.
Newborns' and Mothers' Health Protection Act (NMHPA)	Group health plans that provide maternity or newborn infant coverage.	**Statement** within the SPD (or SMM) time frame.	The plan's SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the Federal law applies in some areas in which the plan operates and State law applies in other areas, the SPD should describe the different areas and the Federal or State requirements applicable in each.
Uniformed Services Employment and Reemployment Rights Act (USERRA)	All public and private employers, regardless of size.	Provide **notice** by posting where other employee notices are customarily posted, or provide to employees by alternate means.	Employers must provide notice of rights, benefits and obligations of persons entitled to USERRA and of employers.
Women's Health and Cancer Rights Act (WHCRA)	Group health plans that provide coverage for mastectomy benefits.	Provide **notice** upon enrollment in the plan and annually thereafter.	The DOL has published sample language for both the enrollment notice and the annual notice. Enrollment notice should include a statement that for participants and beneficiaries who are 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 product a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. Notice should also include a description of any deductibles and co-insurance limitations applicable to such coverage. Annual notice should include a copy of the WHCRA enrollment notice, or a simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description.

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices *continued*

Law	Governs	Notice Requirement	Summary
Genetic Information Non-discrimination Act (GINA) – Employment Provisions **EFFECTIVE NOVEMBER 21, 2009**	Employers in the private sector and State and local governments that employ 15 or more employees.	No general notice requirements. **Individual notice** required if genetic information used for toxic substance monitoring or for certain disclosures of genetic information.	Employers that want to obtain genetic information of employees in order to monitor the biological effects of exposure to toxic substances in the workplace must provide written notice to each affected employee of the genetic monitoring. The employee must authorize the monitoring, unless it is required by law. Additional requirements apply to genetic monitoring. Employers generally may not disclose an employee's genetic information. Certain exceptions apply to this rule, including disclosure of genetic information in response to a court order or to public health agencies regarding contagious, life-threatening illness. Notice to the employee is required if the employer discloses genetic information for these purposes.
HIPAA – Wellness Programs	Group Health Plans and Insurers that offer Wellness Programs that condition a reward based on outcome.	Plan years beginning on or later July 1, 2007 – **plans must disclose** the availability of an alternative standard in all materials describing the wellness program.	Wellness programs which offer a reward conditioned upon an individual's ability to meet a standard that is related to a health factor will violate HIPAA non-discrimination rules unless the program satisfies a number of conditions: • Limit reward to 20% of cost of coverage; • Design to reasonably promote health and prevent disease; • Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard. The regulations provide safe harbor language for this disclosure.
Qualified Medical Child Support Orders	Plan administrators of group health plans and State child support enforcement agencies.	**Medical child support order notice** – upon receipt of medical child support order, plan administrator must promptly **issue notice**, including plan's procedures for determining its qualified status. Within a reasonable time after its receipt, plan administrator must also issue **separate notice** as to whether the medical child support order is qualified.	This is a notification from the plan administrator regarding receipt and qualification determination on a medical child support order directing the plan to provide health insurance coverage to a participant's noncustodial children.
		National Medical Support notice – Within 20 days after the date of notice or sooner, if reasonable, employer must either send Part A to State agency, or Part B to plan administrator. Plan administrator must promptly notify affected persons of receipt of notice and procedures for determining its qualified status. Plan administrator must within 40-business days after its date or sooner, if reasonable, complete and return Part B to State agency and must provide required information to affected persons. Under certain circumstances, employer may be required to send Part A to State agency after plan administrator has processed Part B. *	Notice used by State agency responsible for enforcing health care coverage provision in a medical child support order. Depending upon certain conditions, employer must complete and return Part A of the National Medical Support notice to the State agency or transfer Part B of the notice to the plan administrator for a determination on whether the notice is qualified medical child support order. *

*Source: *"Reporting and Disclosure Guide for Employee Benefit Plans,"* U.S. Dept. of Labor, EBSA, reprinted October 2008.

This document is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.
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ERISA - Electronic Distribution of ERISA Disclosures

Department of Labor (DOL) **regulations** contain a safe harbor under which ERISA plans may use electronic means to distribute certain documents and other required ERISA information. Summary plan descriptions (SPDs), summaries of material modifications (SMMs), summary annual reports (SARs), COBRA notices, qualified domestic relations orders (QDROs) and qualified medical child support orders (QMCSOs), for example, can all be distributed electronically if certain conditions are met.

The Affordable Care Act (ACA) creates additional disclosure requirements for group health plans and employers, such as the summary of benefits and coverage (SBC) and a notice about ACA's health insurance Exchanges (Exchange Notice). The SBC and the Exchange Notice may be distributed electronically if certain requirements are met.

This Legislative Brief summarizes the DOL's safe harbor for electronic distribution of disclosures required by ERISA. It also addresses the requirements for electronic distribution of ACA's Exchange Notice and SBC.

WHAT TYPE OF DISCLOSURES CAN A PLAN ADMINISTRATOR SEND ELECTRONICALLY?

The DOL's safe harbor regulations allow plan administrators to send disclosures required under Title I of ERISA electronically. Such disclosures include:

- SPDs, SMMs and SARs;
- COBRA notifications;
- QMCSO notices; and
- HIPAA certificates of creditable coverage.

In addition, employers that satisfy the DOL's safe harbor requirements may distribute the Exchange Notice electronically.

As described more below, a different set of rules applies for electronic distribution of the SBC to participants and beneficiaries. In general, these rules make it simple to provide the SBC electronically to participants and beneficiaries in connection with their online enrollment or online request for an SBC.

The requirements for sending documents electronically do not change any standards regarding who is entitled to a disclosure, the content of the disclosure or the timing of the disclosure.

DOL SAFE HARBOR FOR ELECTRONIC DISCLOSURE

May Plan Administrators Electronically Distribute ERISA Disclosures To All Recipients?

The regulations contain guidelines for providing disclosures to:

- Employees with **work-related computer access**; and
- Other plan participants and beneficiaries who **consent** to receive disclosures electronically.

Employees with Work-related Computer Access

You may deliver ERISA disclosures electronically to employees that:

- Have the ability to effectively access documents furnished in electronic form at any location where the employees are reasonably expected to perform their duties; and
- Are expected to have access to the employer's electronic information system as an integral part of those duties.

Merely providing employees with access to a computer in a common area (for example, a computer kiosk) is not a permissible means to electronically furnish ERISA-required documents.

Beneficiaries and Other Plan Participants Who Consent to Receive Disclosures Electronically

A plan administrator must obtain written consent prior to electronically delivering ERISA disclosures to beneficiaries and other plan participants who do not have work-related access to a computer. The consent may be received in either electronic or paper form. Prior to consenting, an individual must be given a clear and conspicuous statement that explains:

- The types of documents to which the consent will apply;
- That consent can be withdrawn at any time without charge;
- The procedures for withdrawing consent and for updating the address used for receipt of electronically furnished documents;
- The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and
- Hardware or software needed to access and retain the documents delivered electronically.

Where the electronic distribution is made through the Internet, the individual must affirmatively consent in a manner that reasonably demonstrates his or her ability to access information in the electronic form that would be used.

If the plan administrator changes its hardware or software requirements, it must provide a new notice and obtain a new consent.

What General Disclosure Requirements Apply To All Electronic Disclosures?

Plan administrators are required to use measures reasonably calculated to ensure **actual receipt** of the material by plan participants and beneficiaries. The regulations provide some guidance on what measures are reasonably calculated to ensure actual receipt when electronic delivery is used.

Notices

A notice must be sent electronically or in paper form to each plan participant or beneficiary at the time the document is provided electronically. The notice must:

- Indicate the significance of the document when it is not otherwise reasonably evident as transmitted; and
- Explain the participant's right to request a paper copy.

Confirmation of Receipt

The plan administrator must make use of electronic mail features such as return-receipt or notice that the e-mail was not delivered. The plan must also conduct periodic reviews to confirm receipt of the transmitted information.

Confidentiality

When personal information pertaining to an individual's benefits or accounts is transmitted electronically, steps must be taken to protect the confidentiality of the information.

Style, Format and Content Requirements

Documents delivered electronically must continue to be furnished in a manner consistent with the applicable style, format and content requirements contained within ERISA. For example, summary plan descriptions provided electronically must contain all the disclosures otherwise required by ERISA's disclosure requirements. The DOL has indicated that the appearance of paper and electronic versions need not be identical.

Paper Copy

Plan participants and beneficiaries are entitled to receive a paper copy of any ERISA disclosure provided electronically. Where a plan participant or beneficiary requests a paper copy of a document originally provided electronically, the general rules governing whether a plan administrator may or may not charge for paper copies apply.

Can Benefit and Claim Determinations Be Provided Electronically?

Yes. The regulations provide that benefit and claims determinations related to a specific individual may be communicated electronically to that individual. However, where the information contained within the communication is confidential in nature or protected health information subject to the HIPAA Privacy Rules, the plan administrator must take appropriate and necessary steps to ensure that the information remains confidential.

What Forms of Electronic Disclosure Are Permissible?

The regulations do not require the use of any specific form of electronic media. Examples of permissible forms of electronic disclosure include delivery of documents by e-mail, attachment to an e-mail, posting documents on a company website, or on CD-ROM or DVD.

May a Plan Administrator Electronically Deliver ERISA Notices By Placing the Information on a Company Website?

Under the guidelines contained within the regulations, merely placing an SPD on a company website available to employees will not by itself satisfy ERISA's disclosure Requirements. The plan administrator must also send a notice, electronically or in paper form, that notifies the employee that the SPD is available on the website.

A plan administrator that intends to distribute SPDs, SMMs and SARs electronically might do the following:

- Post SPDs, SMMs and SARs on a company website available to all employees;
- Obtain consent to electronically deliver SPDs, SMMs and SARs from employees and COBRA participants that do not have regular work-related computer access. For example, employees working for a manufacturer in the plant may agree to access the website from his or her home computer;
- Send an e-mail notice to all employees that have work-related computer access or that have provided consent each time an SPD, SMM or SAR is posted on the website. Use e-mail features such as return receipt and notice of non-delivery;
- Continue to provide in paper form copies of SPDs, SMMs and SARs to employees that do not have regular work-related computer access and that have not provided consent; and
- Continue to provide in paper form copies of SPDs, SMMs and SARs upon request free of charge.

Note: The plan administrator is generally not required to distribute SPDs, SMMs or SARs to each beneficiary under the plan. Therefore, the plan administrator is not required to obtain consent from each beneficiary under the plan (for example, spouses and dependent children).

May a Plan Administrator Electronically Deliver COBRA Notices By Placing the Information on a Company Website or Sending Them Via E-Mail?

Yes, the rules allow plan administrators to provide COBRA notices electronically. However, because COBRA notices must be provided via first-class mail to the home address where a spouse or dependent is also covered under the plan, the plan administrator must obtain consent from the spouse or dependent before delivering COBRA notices electronically. Therefore, providing COBRA notices electronically may not be as practical as electronically delivering SPDs, SMMs or SARs.

DO SPECIAL RULES APPLY TO THE SBC?

The SBC must be provided by a group health plan or issuer to participants and beneficiaries in connection with enrollment and renewal and upon request. It may be provided in either paper or electronic form (such as by e-mail or an Internet posting). The requirements for electronic delivery of the SBC generally depend on whether the SBC is provided in connection with an online enrollment or under other circumstances.

In addition, the **uniform glossary** is a separate document that is a companion to the SBC. The SBC must include an Internet address for obtaining the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary and a disclosure that paper copies are available.

Online Enrollment

A set of Frequently Asked Questions (FAQs) on ACA implementation establish a safe harbor for electronic delivery of the SBC in connection with online enrollment. Under this safe harbor, the SBC may be provided electronically to participants and beneficiaries in connection with their **online enrollment or online renewal of coverage** under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request.

Other Circumstances

If the online enrollment safe harbor does not apply, the final regulations contain two rules for electronic distribution of the SBC. These rules may apply, for example, if a plan does not have an online enrollment system or if the plan allows paper or telephone enrollment in addition to online enrollment.

Individuals Covered under the Plan

The SBC may be delivered electronically to participants and beneficiaries who are already covered under the group health plan if the DOL's safe harbor for electronic disclosure is satisfied.

Eligible Individuals Not Enrolled

For participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

- The format is readily accessible;
- The SBC is provided in paper form free of charge upon request; and
- If the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or e-mail that the documents are available on the Internet, provides the Internet address and notifies the individual that the documents are available in paper form upon request.

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) *continued*

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 January 31, 2014. You should contact your State for further information on eligibility:

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

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

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on 'Programs', then 'Medicaid', then 'Health Insurance Premium Payment (HIPP)'
Phone: 1-800-869-1150

IDAHO – Medicaid
Medicaid Website:
http://healthandwelfare.idaho.gov/medical/medicaid/premiumassistance/tabid/1510/default.aspx
Medicaid Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

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

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TEXAS – Medicaid
Website: http://www.gethipptexas.org/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820 (HMS Third Party Liability)

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2014, 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.

COBRA - General Notice of COBRA Continuation Coverage Rights *continued*

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:

Michael Brunn

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.

COBRA - General Notice of COBRA Continuation Coverage Rights *continued*

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:

Contact Name (or position): Michael Brunn

Address: 140 Main Street Menasha WI 54952

Phone Number: 920 967-3604

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.

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 Michael Brunn .

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 [redacted] (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 [redacted] . [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 [redacted] 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 vent 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.

HIPAA - Notice of Privacy Practices *continued*

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:	Michael Brunn
Organization's Name:	City of Menasha
Street Address:	140 Main Street
City / State / Zip:	Menasha WI 54952
Phone Number:	920 967-3604
e-Mail Address:	mbrunn@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

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

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.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

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**.

HIPAA – Portability Rights and Special Enrollment Rights *continued*

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:	Michael Brunn
Street Address:	140 Main Street
City / State / Zip:	Menasha WI 54952
Telephone:	920 967-3604

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.

Model HIPAA Exemption Election / Election Renewal Document

The following may be submitted on plan sponsor's or plan administrator's letterhead:

Name of Plan:

Plan Sponsor: City of Menasha

Address: 140 Main Street

City / State / Zip: Menasha WI 54952

EIN: **Plan Number** (if applicable):

Plan Year/Period of Plan coverage: through
(may reflect multiple plan years governed by a collective bargaining agreement.)

Plan Administrator: Michael Brunn

Address: 140 Main Street

City / State / Zip: Menasha WI 54952

is not provided through insurance.
City of Menasha elects under authority of Section 2721(b)(2) of the Public Health Service (PHS) Act, and 45 CFR 146.180 of Federal regulations, to exempt from the following requirements of Title XXVII of the PHS Act (list any or all of the following requirements):

- ☐ Limitations on preexisting condition exclusion periods.
- ☐ Special enrollment periods.
- ☐ Prohibitions against discriminating against individual participants and beneficiaries based on health status.
- ☐ Standards relating to benefits for mothers and newborns.
- ☐ Parity in the application of certain limits to mental health benefits.
- ☐ Required coverage for reconstructive surgery following mastectomies.
- ☐ Coverage of dependent students on medically necessary leave of absence.

This election has been made in conformity with all rules of the plan sponsor, including any public hearing, if required.
I certify that the undersigned is authorized to submit this election on behalf of City of Menasha
A copy of the notice to plan enrollees is enclosed. (In the case of an election renewal, in lieu of enclosing a copy of an updated notice to plan enrollees, the plan sponsor may include a statement that the notice has been, or will be, provided to plan enrollees in accordance with 45 CFR 146.180(f).) If CMS has any questions regarding this election, please contact Michael Brunn at 920 967-3604 .

Signature:

Title:

Medicare Part D - Individual Creditable Coverage Disclosure Notice Language

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 _____, 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.

Medicare Part D - Individual Creditable Coverage Disclosure Notice Language *continued*

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).

Medicare Part D - Individual Non-Creditable Coverage Disclosure Notice Language

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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Three 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 _____ is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the _____. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from City of Menasha. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully as it explains your options.

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.

IF EMPLOYER/UNION SPONSORED GROUP PLAN: However, if you decide to drop your current coverage with City of Menasha, since it is employer/union sponsored group coverage; you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. However, you also may pay a higher premium (a penalty) because you did not have creditable coverage under _____.

IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE COVERAGE: Since you are losing creditable prescription drug coverage under the _____, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the coverage under _____, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 9 – 11 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.

Medicare Part D - Individual Non-Creditable Coverage Disclosure Notice Language *continued*

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You will receive 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 get 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)**.

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.