Focus on Benefits
We encourage you to read the entire enrollment guide before you enroll.
This is a summary of your benefits only. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to your Summary Plan Description or Certificate of Coverage. If information in this summary differs from the Summary Plan Description or Certificate of Coverage, the Summary Plan Description or Certificate of Coverage is the ruling document.
WELCOME TO YOUR BENEFITS

At the Mequon-Thiensville School District, we value our employees and are committed to providing a comprehensive and competitive benefits package. Since the benefits provided to you are an important part of your total compensation, you are encouraged to take some time to read this Focus on Benefits and become familiar with its contents. This guide gives you a brief description of the benefits offered and is not intended to be a complete source of information on the plans. For more detailed information on each of the plans, please refer to the Summary Plan Descriptions and Certificate of Coverage.

NEW HIRE ENROLLMENT

Benefit eligibility:

- Teachers, administrators and support personnel are eligible for benefits if they work at least 75% of a full time equivalency.

- Support personnel are eligible for benefits if they work at least 9 months of the year for at least 30 hours per week.

- All employees are eligible for benefits if they meet full time status under the affordable care act look-back measurement rules.

Benefit effective date:

- Benefits are effective the 1st of the month following your active paid employment date.

Please make your benefit elections within 30 days of your start date by turning in your completed forms to Payroll.

OPEN ENROLLMENT

Each year you have the opportunity to review your benefit options and make choices based upon your current life situation. Open enrollment for medical and dental insurance is generally in the month of May and open enrollment for flexible spending plans is generally in the month of November. You will receive more detailed communication about open enrollment periods as they occur during the year.

CHANGING BENEFIT ELECTIONS

Making changes to your coverage during the plan year

To protect the tax advantages of your benefits, the district is required to follow certain IRS rules. These rules effect when you may change your benefits and what changes you may make. You can make changes during the annual open enrollment period and if you experience a qualifying event during the year.
Qualifying Event: You may change your benefit elections mid-year if you experience a qualifying event. A sample of events are provided below, please see your HR department for a full list:

- The addition of dependents due to the birth or adoption of a child
- Your marriage or divorce
- The death of one of your dependents
- A change in the employment status of your spouse or dependent, including the termination or commencement of employment, loss of work due to a strike or lockout

Notification must be made within 30 days of the event.

Dependent Eligibility

Eligible dependents include:

- Your legal spouse
- Dependent children up to the age of 26.
- Your physically or mentally disabled children beyond age 26 if meeting specific criteria established by insurance company.

Ultimately determination of eligibility is based on the terms, conditions and limitation of the plan document.
When coverage begins and ends

School year support staff and teachers benefits begin on September 1st and end on August 31st each year.

Year round employee benefits begin on July 1st and end on June 30th each year.

Remember, due to Internal Revenue Service (IRS) regulations, changes can only be made to your enrollment elections during open enrollment or if you experience a qualifying event that allows you to make a change mid-year.

BENEFIT OVERVIEW

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Your options</th>
<th>Coverage levels</th>
<th>Cost sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>WEA Medical Plan</td>
<td>Single Family</td>
<td>Cost is shared between district and employee</td>
</tr>
<tr>
<td>Dental</td>
<td>Delta Dental Plan</td>
<td>Single Family</td>
<td>Cost is shared between district and employee</td>
</tr>
<tr>
<td>Basic term life insurance</td>
<td>Kansas City Life</td>
<td>Employee</td>
<td>Cost is paid by the district</td>
</tr>
<tr>
<td>Medical Flexible Spending Account</td>
<td>Contribute up to $2,600 per calendar year on a pre-tax basis</td>
<td>Employee</td>
<td>Contribution is made by the employee</td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account</td>
<td>Contribute up to $5,000 per calendar year on a pre-tax basis</td>
<td>Employee</td>
<td>Contribution is made by the employee</td>
</tr>
<tr>
<td>Long term disability</td>
<td>Kansas City Life</td>
<td>Employee</td>
<td>Cost is paid by the district</td>
</tr>
</tbody>
</table>

HEALTH PLAN FEATURES

Our health plan provider is the WEA Trust. Highlighted below are some tools and resources offered by your plan:

Amwell - telemedicine

Doctor e-visits available 24 hours a day, 7 days a week using your smartphone, tablet or computer.

Physicians can diagnose, recommend treatment and write short term prescriptions (non DEA controlled substances). There is no cost to you.

Register at www.weatrust/amwell.com so you are ready for a visit if needed. Or, download the
Amwell app on your mobile device. (enter the service key “trust”).

**Smart Choice MRI**

High quality, lower cost imaging services

Five area locations: Milwaukee, Sheboygan, Kenosha, Richfield, Waukesha

Scans are read by board certified radiologists and sent to any physician

Bonus incentive – WEA offers you a $100 Visa gift card following your scan

Call (844) 633-3674 to schedule

**Orthopedic Sports Institute**

If you need to undergo orthopedic surgery, the Trust’s partnership with OSI provides an option for unified care. For example, your knee replacement has a roadmap including advanced imaging, surgery, recovery and physical therapy. Quality care with easy scheduling and coordination.

When you choose to have a procedure done at OSI, WEA offers you a $250 Visa gift card.

To learn more or schedule an appointment visit [www.OSIFV.com](http://www.OSIFV.com)

**Harmony Care Management**

Provides a single point of contact to help with your medical care. Harmony can help with chronic condition management, finding the right provider for you and taking the stress out of hospital stays.

There are self-serve resources available at [www.WEAtrust.com/Harmony](http://www.WEAtrust.com/Harmony). Or, you can complete an on-line request form for individual assistance.

**Livongo for Diabetes**

Livongo provides valuable tools that make living with diabetes easier including In Touch Blood Glucose Monitoring System, unlimited test strips and other supplies at no cost to you. The smart monitor tracks your readings and is cellular enabled.

To enroll visit [www.livongo.com/WEATrust](http://www.livongo.com/WEATrust), click enroll now and enter registration code TRUSTDM

You will received your starter kit in one week.
HEALTH PLAN BENEFIT SUMMARY (2017-18)

<table>
<thead>
<tr>
<th>Trust Preferred Essential Qualified Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
</tr>
<tr>
<td>Single (in-network/out-of-network)</td>
</tr>
<tr>
<td>Family (in-network/out-of-network)</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
</tr>
<tr>
<td>In-network</td>
</tr>
<tr>
<td>Out-of-network</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
</tr>
<tr>
<td><strong>Deductible, Coinsurance and Office Visit</strong></td>
</tr>
<tr>
<td>Single (in-network/out-of-network)</td>
</tr>
<tr>
<td>Family (in-network/out-of-network)</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
</tr>
<tr>
<td><strong>Pharmacy Only</strong></td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
</tr>
<tr>
<td>Office visit</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
</tr>
<tr>
<td>Urgent Care</td>
</tr>
<tr>
<td>Emergency Room</td>
</tr>
<tr>
<td>All other medical and hospital services</td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
</tr>
<tr>
<td>30 day retail pharmacy: value/ tier 1/ tier 2/ tier 3</td>
</tr>
<tr>
<td>90 mail order: value/ tier 1/ tier 2/ tier 3</td>
</tr>
<tr>
<td>180 mail order: value/ tier 1/ tier 2/ tier 3</td>
</tr>
</tbody>
</table>
HEALTH PLAN RATES (assuming wellness plan participation)

Full-time teachers, administrators and 12 month educational support personnel

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>.89 to 1.00 FTE</th>
<th>.85 FTE</th>
<th>.80 FTE</th>
<th>.75 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Cost – Monthly</td>
<td>$87.05</td>
<td>$118.70</td>
<td>$158.26</td>
<td>$197.83</td>
</tr>
<tr>
<td>Family Cost - Monthly</td>
<td>$198.68</td>
<td>$270.93</td>
<td>$361.24</td>
<td>$451.55</td>
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</table>

9 month educational support personnel

<table>
<thead>
<tr>
<th>Coverage level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Cost - Monthly</td>
<td>$87.05</td>
</tr>
<tr>
<td>Family Cost - Monthly</td>
<td>$541.85</td>
</tr>
</tbody>
</table>
Vitality Wellness Program

Vitality helps you know your current health status, improve your health based on your specific goals and earn rewards along the way. The program is easy to access online or on your phone, with fun activities designed to fit into your busy life.

Learn more at www.WEAtrust.com/Vitality

To maintain the lowest monthly cost for your health insurance benefit, you must participate in the wellness program components described below. If you are hired after October 1st, your participation in the program is not required in your first year of employment.

Step 1:

A. Participate in the onsite biometric health screening (coming to our facilities in September 2017)
B. Complete the Vitality Health Review (health risk assessment)
C. Review your health information with a health screening specialist

Complete this step by November 1st to be eligible for the continued premium discount. Failure to complete this step will result in an increase to your health insurance contribution for the remainder of the plan year effective December 1st (see rate table at end of section).

Step 2:

Participate in the Vitality and earn points. To maintain a lower monthly premium into the next plan year, you must show progress on your goals and points accumulated in Vitality. More details regarding this requirement will be distributed soon.

HEALTH PLAN RATES (failure to meet wellness program steps)

Full-time teachers, administrators and 12 month educational support personnel

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>.89 to 1.00 FTE</th>
<th>.85 FTE</th>
<th>.80 FTE</th>
<th>.75 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Cost – Monthly</td>
<td>$118.70</td>
<td>$150.35</td>
<td>$189.92</td>
<td>$229.48</td>
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<tr>
<td>Family Cost - Monthly</td>
<td>$270.93</td>
<td>$343.17</td>
<td>$433.48</td>
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9 month educational support personnel

<table>
<thead>
<tr>
<th>Coverage level</th>
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</thead>
<tbody>
<tr>
<td>Single Cost - Monthly</td>
<td>$118.70</td>
</tr>
<tr>
<td>Family Cost - Monthly</td>
<td>$614.10</td>
</tr>
</tbody>
</table>
Opting Out of Health Plan

Employees who are eligible for family health insurance may elect to waive health insurance and receive cash compensation. Employees who wish to waive health insurance must demonstrate that they have other coverage.

For the 2017-18 plan year, full time employees who chose to waive insurance will receive cash compensation in the amount of $5,500. This amount will be divided into 20 equal payments and paid semi-monthly between September and June. Employees working less than full time but greater than 75% will receive a prorated amount.

Employees who choose to opt out must continue with that option until the next open enrollment period or must have a qualifying event in order to enroll in the district health plan. Enrollment in the district’s health plan outside of open enrollment is subject to the carrier’s late enrollment terms, timelines and conditions of reentry.

Employees who wish to opt out MUST complete an opt-out enrollment form. This form must be completed each year and returned to payroll.
DENTAL PLAN BENEFITS AND FEATURES

Delta Dental Plan
Our group dental plan is with Delta Dental.

Dental Plan Networks
Coverage is offered through three network options: Delta PPO, Delta Premier and Non-network.

See the plan summary located on the next page; electing a PPO Dentist provides a greater benefit (lower deductible and greater basic services coverage).

Members can search for network dental providers by following these instructions:
1. Go to www.deltadentalwi.com  Go to ‘Provider Search’ and select ‘Find a Network Dentist’
2. Then enter your zip code and the provider results will indicate if a Dentist is Delta PPO and/or Premier and if they are accepting new patients.
## DENTAL PLAN BENEFIT SUMMARY

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta PPO</th>
<th>Delta Premier</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible limit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$25</td>
<td>$25</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$75</td>
<td>$75</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Diagnostic and preventive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>X-rays*</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Cleanings</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Topical Fluoride</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>*bitewing once per 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and full mouth once every 5 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
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<tr>
<td>Stainless Steel Crowns</td>
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<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
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<tr>
<td>Simple extraction</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
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<tr>
<td>Simple Endodontics</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
</tr>
<tr>
<td>Simple Periodontics</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
</tr>
<tr>
<td><strong>Major services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
</tr>
<tr>
<td>Complex Endodontics</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
</tr>
<tr>
<td>Complex Periodontics</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
</tr>
<tr>
<td>Porcelain Crowns</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
</tr>
<tr>
<td>Inlays/Onlays</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
</tr>
<tr>
<td>Dentures</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
</tr>
<tr>
<td>Denture repair</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
<td>Deductible, 80%</td>
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<tr>
<td>Removable or Fixed Bridgework</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
<td>Deductible, 50%</td>
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<tr>
<td><strong>Annual benefit maximum</strong></td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependents to age 26</td>
<td>$1,500 lifetime maximum Deductible, 50%</td>
<td>$1,500 lifetime maximum Deductible, 50%</td>
<td>$1,500 lifetime maximum Deductible, 50%</td>
</tr>
</tbody>
</table>
DENTAL PLAN RATES

Full-time teachers, administrators and 12 month educational support personnel

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>1.00 FTE</th>
<th>.95 FTE</th>
<th>.90 FTE</th>
<th>.85 FTE</th>
<th>.80 FTE</th>
<th>.75 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Cost – Monthly</td>
<td>$0.00</td>
<td>$1.81</td>
<td>$3.62</td>
<td>$5.42</td>
<td>$7.23</td>
<td>$9.04</td>
</tr>
<tr>
<td>Family Cost - Monthly</td>
<td>$0.00</td>
<td>$5.27</td>
<td>$10.54</td>
<td>$15.81</td>
<td>$21.08</td>
<td>$26.35</td>
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</table>

9 month educational support personnel

<table>
<thead>
<tr>
<th>Coverage level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Cost - Monthly</td>
<td>$1.81</td>
</tr>
<tr>
<td>Family Cost - Monthly</td>
<td>$5.27</td>
</tr>
</tbody>
</table>
FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts allow you to set aside money to pay for eligible expenses with tax-free dollars.

The spending accounts offer significant tax advantages because you don’t pay Social Security, Federal or State taxes on the portion of your income that you contribute to your spending account.

Because you don’t pay taxes on the money you contribute to your account, you gain an easy way to save money while paying for expenses you expect to incur.

Your choices

1. Healthcare Flexible Spending Account: Use this account to cover the cost of health, dental, vision and hearing expenses which are not covered under an insurance plan for you and your dependents which are considered an eligible healthcare FSA expenses. You may contribute up to $2,600 per year.

2. Dependent Care Spending Account: Use this account to cover the cost of dependent care while you work. You may use this for expenses for the care of a child under age 13 or a disabled spouse, child or parent. If you are married, your spouse must be employed or attending classes full time for you to use the Dependent Care Spending Account. You may contribute up to $5,000 per year per household to this account or $2,500 per year if you are married and file your taxes separately.

The Flexible Spending Account is administered by TASC. For more information visit www.tasconline.com or call 1-800-422-4661.

Eligible healthcare FSA expenses include:

- Deductibles, coinsurance, and copays
- Prescription drug copays
- Over-the-counter medicines, if prescribed by a doctor
- Medical care items that are not prescription drugs, such as equipment (crutches), supplies (bandages and contact lens solution), and diagnostic devices (blood sugar testing kits)
- Dental expenses, including orthodontia
- Vision expenses, including eye exams, glasses, and contact lenses
- Hearing expenses, including hearing aids and exams
- Mental health expenses (does not include marriage counseling)
- Orthopedic expenses
- Weight loss programs (if medically necessary)
- Medical expenses for certain procedures not covered by your plan, such as laser vision correction

*IRS Publication 502, Medical and Dental Expenses, contains a list of Section 213(d) eligible healthcare FSA expenses. Go to www.irs.gov for a complete copy of the list.*
Flex spending accounts could help you save

<table>
<thead>
<tr>
<th></th>
<th>FSA healthcare</th>
<th></th>
<th>FSA dependent care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With account</td>
<td>Without account</td>
<td>With account</td>
<td>Without account</td>
</tr>
<tr>
<td>Annual salary</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$50,000</td>
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<tr>
<td>Pre-tax FSA</td>
<td>-$2,000</td>
<td>$0</td>
<td>-$5,000</td>
<td>$0</td>
</tr>
<tr>
<td>contribution</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Taxable Income</td>
<td>$48,000</td>
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<td>$45,000</td>
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<td>Estimated taxes</td>
<td>$9,600</td>
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<td>$10,000</td>
</tr>
<tr>
<td>(20%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After-tax expenses</td>
<td>$0</td>
<td>-$2,000</td>
<td>$0</td>
<td>-$5,000</td>
</tr>
<tr>
<td>Net Income</td>
<td>$38,400</td>
<td>$38,000</td>
<td>$36,000</td>
<td>$35,000</td>
</tr>
<tr>
<td>Annual tax savings</td>
<td>$400</td>
<td>$0</td>
<td>$1,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

Eligible dependent care FSA expenses include:
- Child or adult care center that complies with State and Local regulations (not including nursing homes)
- Sitter inside or outside the home
- Day care during school vacation, provided it is not primarily for educational purposes
- Nursery school, even if the school provides educational services
- Relative who cares for eligible dependents, as long as that relative is not your dependent and is age 19 or older

*IRS Publication 503, Child and Dependent Care Expenses, contains a list of expenses eligible for reimbursement under the FSA — Dependent Care. Go to [www.irs.gov](http://www.irs.gov) for a complete copy of the list.*
LIFE AND DISABILITY BENEFITS

Long Term Disability
Group long term disability insurance is provided through Kansas City Life Insurance Company. Benefits include:

- 90% of Salary following 60 day elimination period
- Payment for 24 months based on own occupation (any occupation thereafter)

Cost is paid by Mequon-Thiensville School District

Please see plan document for full coverage details

Basic Life Insurance
Group term life insurance is provided through Kansas City Life Insurance Company. Benefit amount is a percent of salary as follows:

- Administrators: 2 times salary to a max of $360,000
- Teachers: 1 times salary to a max of $200,000
- Educational Support: 1 times salary to a max of $65,000

Cost is paid by Mequon-Thiensville School District

Please see plan document for full coverage details
WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

Following this page, are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

1. HIPAA Notice of Privacy Practices
2. CHIP Notice
3. WHCRA Notice
4. HIPAA Portability Notice – New Hires
5. Initial COBRA Notice – New Hires
NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your rights

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

Your choices

You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our uses and disclosures

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

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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

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

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

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

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

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

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

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by
sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- We will not retaliate against you for filing a complaint.

Your choices

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our uses and disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the terms of this notice

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

Other instructions for this notice

- The notice is effective May 1, 2017
- The privacy contact is Sarah Zelazoski, szelazoski@mtsd.k12.wi.us.
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
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<tr>
<td>Phone: 1-855-692-5447</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
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<tr>
<td>Phone (Outside of Anchorage): 1-888-318-8890</td>
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<tr>
<td>Phone (Anchorage): 907-269-6529</td>
<td></td>
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<tr>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
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<tr>
<td>Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a></td>
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<tr>
<td>Phone: 1-877-438-4479</td>
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<tr>
<td>All other Medicaid</td>
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<tr>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
<td></td>
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<tr>
<td>Phone 1-800-403-0864</td>
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<tr>
<td>State</td>
<td>Medicaid/CHIP Website/Phone</td>
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<tr>
<td>COLORADO – Medicaid</td>
<td><a href="http://www.colorado.gov/hcpf">Website</a></td>
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| Medicaid Website: [http://www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)  
Medicaid Customer Contact Center: 1-800-221-3943 |   |   |   |
| FLORIDA – Medicaid | [Website](http://flmedicaidtplrecovery.com/hipp) | KANSAS – Medicaid | [Website](http://www.kdheks.gov/bcf) Phone: 1-785-296-3512 |
| Medicaid Website: [http://flmedicaidtplrecovery.com/hipp](http://flmedicaidtplrecovery.com/hipp)  
Phone: 1-877-357-3268 |   |   |   |
| KENTUCKY – Medicaid | [Website](http://chfs.ky.gov/dms/default.htm) | NEW HAMPSHIRE – Medicaid | [Website](http://www.dhhs.nh.gov/oii/documents/hippapp.pdf)  
Phone: 603-271-5218 |
| Medicaid Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570 |   |   |   |
| LOUISIANA – Medicaid | [Website](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331) | NEW JERSEY – Medicaid | [Website](http://www.state.nj.us/humanservicess/dmhs/clients/medicaid)  
Medicaid Phone: 609-631-2392  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |
| Medicaid Website: [http://dhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)  
Phone: 1-888-695-2447 |   |   |   |
| MAINE – Medicaid | [Website](http://www.maine.gov/dhhs/ofi/public-assistance/index.html) | NEW YORK – Medicaid | [Website](http://www.nyhealth.gov/health_care/medicaid) Phone: 1-800-541-2831 |
Phone: 1-800-442-6003  
TTY: Maine relay 711 |   |   |   |
| MASSACHUSETTS – Medicaid and CHIP | [Website](http://www.mass.gov/MassHealth) | NORTH CAROLINA – Medicaid | [Website](http://www.ncdhhs.gov/dma) Phone: 919-855-4100 |
| Medicaid Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120 |   |   |   |
| MINNESOTA – Medicaid | [Website](http://mn.gov/dhs/ma) | NORTH DAKOTA – Medicaid | [Website](http://www.nd.gov/dhs/services/medicalserv/medicaid)  
Phone: 1-844-854-4825 |
| Medicaid Website: [http://mn.gov/dhs/ma](http://mn.gov/dhs/ma)  
Phone: 1-800-657-3739 |   |   |   |
<table>
<thead>
<tr>
<th>MISSOURI – Medicaid</th>
<th>OKLAHOMA – Medicaid and CHIP</th>
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<tr>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td></td>
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<tr>
<td>Phone: 573-751-2005</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
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<td>Phone: 1-888-365-3742</td>
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<tr>
<th>MONTANA – Medicaid</th>
<th>OREGON – Medicaid</th>
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<tr>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td></td>
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<tr>
<td>Phone: 1-800-694-3084</td>
<td>Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a></td>
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<td></td>
<td><a href="http://www.hijossaludablesoregon.gov">http://www.hijossaludablesoregon.gov</a></td>
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<td>Phone: 1-800-699-9075</td>
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<tr>
<th>NEBRASKA – Medicaid</th>
<th>PENNSYLVANIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a></td>
<td></td>
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<tr>
<td>Phone: 1-855-632-7633</td>
<td>Website: <a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a></td>
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<td>Phone: 1-800-692-7462</td>
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<tr>
<th>NEVADA – Medicaid</th>
<th>RHODE ISLAND – Medicaid</th>
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<tr>
<td>Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a></td>
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<tr>
<td>Medicaid Phone: 1-800-992-0900</td>
<td>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
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<td></td>
<td>Phone: 401-462-5300</td>
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<tr>
<th>SOUTH CAROLINA – Medicaid</th>
<th>VIRGINIA – Medicaid and CHIP</th>
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<tr>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
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<tr>
<td>Phone: 1-888-549-0820</td>
<td>Medicaid Website:</td>
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<tr>
<td></td>
<td><a href="http://www.coverva.org/programs_premium_assistance.aspx">http://www.coverva.org/programs_premium_assistance.aspx</a></td>
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<tr>
<td></td>
<td>Medicaid Phone: 1-800-432-5924</td>
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<td></td>
<td>CHIP Website:</td>
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<tr>
<td></td>
<td><a href="http://www.coverva.org/programs_premium_assistance.aspx">http://www.coverva.org/programs_premium_assistance.aspx</a></td>
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<td>CHIP Phone: 1-855-242-8282</td>
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<tr>
<th>SOUTH DAKOTA - Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Page/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Page/default.aspx</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<td>UTAH – Medicaid and CHIP</td>
<td>WISCONSIN – Medicaid and CHIP</td>
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<td>Website:</td>
<td>Website:</td>
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<tr>
<td>Phone: 1-877-543-7669</td>
<td>Phone: 1-800-362-3002</td>
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<tr>
<th>VERMONT – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
</tr>
<tr>
<td>Phone: 1-800-250-8427</td>
<td>Phone: 307-777-7531</td>
</tr>
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To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565
NOTICE OF RIGHTS UNDER THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government enacted the Women’s Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy. This memo is intended to provide participants and beneficiaries with notice of their rights under the Women’s Health and Cancer Rights Act.

Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

Please contact the Human Resources Department or the company’s health insurance carrier directly for more information on your rights under the Women’s Health and Cancer Rights Act.
HIPAA PORTABILITY NOTICE

Our records show that you are eligible to participate in the company’s Group Health Plan (to actually participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

Special enrollment rights

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

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

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state’s Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact Human Resources.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more 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 it would otherwise end because of a life event. This is also called 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 must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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.”

When is COBRA continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.
How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

To protect your family’s rights, let the Plan Administrator know about 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

Please contact the Human Capital department for plan information or questions.
NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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 credit¹.

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 Kim Gehring, Payroll and Benefits Specialist, at 262 238-8508.

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.

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.
for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about health coverage offered by your employer

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

3. Employer name: Mequon-Thiensville School District

4. Employer Identification Number (EIN): 39-1167661

5. Employer address: 5000 W. Mequon Rd. 6. Employer phone number: 262 238-8508


10. Who can we contact about employee health coverage at this job?: Kim Gehring, Payroll and Benefits Manager

11. Phone number (if different from above) 12. Email address: kgehring@mtsd.k12.wi.us

Here is some basic information about health coverage offered by this employer

As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

X Some employees. Eligible employees are:

• Teachers, administrators and support personnel are eligible for benefits if they work at least 75% of a full time equivalency.

• Support personnel are eligible for benefits if they work at least 9 months of the year for at least 30 hours per week.

• All employees are eligible for benefits if they meet full time status under the affordable care act look-back measurement rules.

With respect to dependents:

X We do offer coverage. Eligible dependents are defined in the summary plan description

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit.
to lower your monthly premiums.
This Focus on Benefits provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern.

The Mequon-Thiensville School District reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Focus on Benefits is not a contract, and participation in any of the plans does not guarantee employment.