2024 BENEFITS GUIDE

PORT WASHINGTON
WISCONSIN

BENEFITS OVERVIEW

City of Port Washington is committed to offer a comprehensive benefits package to eligible, full-time employees who work an average of 30 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (Medical and Dental), the City of Port Washington provides other benefits at no cost to you (Life, Short-Term Disability, Long-Term Disability and EAP) and there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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ELIGIBILITY

You and your dependents are eligible for City of Port Washington benefits on the first of the month following date of hire.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact Human Resources within 30 days.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 24-25 for more details.

MEDICAL BENEFITS

Administered by UnitedHealthcare

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way - especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	CHOICE PLUS HDHP	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Calendar Year Deductible	$3,500 single / $7,000 family	$7,500 single / $15,000 family
Calendar Year Out-of-Pocket Maximum	$6,350 single / $12,700 family	$12,700 single / $25,400 family
Coinsurance	10%	30%
DOCTOR'S OFFICE		
Primary Care Office Visit	10% after deductible	30% after deductible
Specialist Office Visit	10% after deductible	30% after deductible
Wellness Care (routine wellness checkups, immunizations, well baby care, mammograms and colorectal cancer screenings)	0%	30% after deductible
PRESCRIPTION DRUGS		
Retail—Tier 1 (30-day supply)	$10 after deductible	$10 after deductible
Retail—Tier 2 (30-day supply)	$35 after deductible	$35 after deductible
Retail—Tier 3 (30-day supply)	$70 after deductible	$70 after deductible
Mail Order—Tier 1 (90-day supply)	$25* after deductible	Not Covered
Mail Order— Tier 2 (90-day supply)	$87.50* after deductible	Not Covered
Mail Order—Tier 3 (90-day supply)	$175* after deductible	Not Covered
HOSPITAL SERVICES		
Emergency Room	10% after deductible	10% after deductible
Urgent Care Center	10% after deductible	30% after deductible
Inpatient	10% after deductible	30% after deductible
Outpatient Surgery	10% after deductible	30% after deductible
Ambulance Service**	10% after deductible	10% after deductible

*Only certain Prescription Drugs Products are available through mail order. Visit myuhc.com for more information.
** Emergency only. Non-Emergency OON is 30% after deductible.

MEDICAL BENEFITS (Continued)

Administered by UnitedHealthcare

	CHOICE PLUS HDHP	
	In-Network	Out-of-Network
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing	Designated Network: 10% after deductible Network: 50% after deductible	30% after deductible
Major Diagnostic and Imaging - Outpatient	Designated Network: 10% after deductible Network: $500 per occurrence, deductible then 50%	$500 per occurrence, deductible then 30%
MENTAL HEALTH SERVICES		
Inpatient Services	10% after deductible	30% after deductible
Outpatient Services	10% after deductible	30% after deductible
SUBSTANCE ABUSE SERVICES		
Inpatient Services	10% after deductible	30% after deductible
Outpatient Services	10% after deductible	30% after deductible
OTHER SERVICES		
Maternity Services	10% after deductible	30% after deductible
All other maternity hospital/ physician services	10% after deductible	30% after deductible
Muscle Manipulation Services	10% after deductible	30% after deductible
Physical Therapy Services (20 visits per year)	10% after deductible	30% after deductible
Occupational Therapy Services (20 visits per year)	10% after deductible	30% after deductible
Speech Therapy Services (20 visits per year)	10% after deductible	30% after deductible
Skilled Nursing (30 days per stay in Facility)	10% after deductible	30% after deductible

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to **www.welcometouhc.com** or call **1.800.782.3740 or**

1.866.673.6293 to find providers in the UnitedHeathcare Network.

HOW THE PLANS WORK

What is a HDHP (High Deductible Health Plan)?

A HDHP plan features lower premiums and higher out-of-pocket costs with deductibles before the plan begins covering costs.

The plan includes 100 percent coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider. Additional preventive screenings and services may also be covered, depending on factors such as your age, gender and certain chronic conditions.

You pay out of pocket until you reach the deductible.

When you have an eligible expense, such as a doctor visit when you're sick, you will pay the full cost of your health expenses until you meet your deductible.

Your plan covers cost of covered services.

Once the deductible is paid, your medical plan has 10% coinsurance. This means once you have met your deductible the plan begins to pay 90% of covered services and you are responsible for 10% until the out of pocket maximum has been reached.

You are protected from major expenses.

An out-of-pocket maximum protects you from major expenses. The out-of-pocket maximum is the most you will have to pay in the plan year for covered health care. Your deductible, coinsurance, medical services and prescription drugs apply toward the out-of-pocket maximum. The HRA benefit helps to lower this amount.

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table on the previous page, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Telemedicine

Getting to the doctor when you're sick is never easy. That's why the City of Port Washington offers telemedicine through UHC. You can connect with a U.S. board-certified doctor 24 hours a day, seven days a week by phone or video chat for minor conditions like a cold or a fever To get started, visit www.myuhc.com and register with your UHC member ID number (found on the back of your medical ID card).

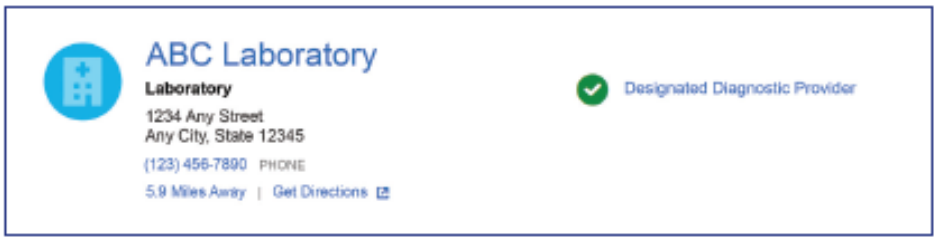
Say hello to the Designated Diagnostic Provider benefit

Designated Diagnostic Providers (DDP) are laboratory and imaging services providers that meet certain quality and efficiency requirements. With your DDP benefit, you'll have the highest level of coverage—and likely save money—when you use a DDP for outpatient lab and imaging services. If you don't use a DDP, your lab and imaging services may not be covered, and you may be responsible for 100% of the cost.

Just look for the green check

To find a lower-cost DDP near you, go to **myuhc.com® > Find Care & Costs > Medical Directory > Places.**

Choose whether you'd like lab or imaging services and then look for the green check to confirm DDP status. For DDP imaging services, just make your appointment. For DDP lab work, just be sure to tell your doctor which DDP to use.



DDP outpatient lab and imaging services

Using a DDP may help you save money on many services, including:

Lab services

- Blood draws
- Blood glucose tests
- Metabolic tests/panels
- Rapid strep tests

Imaging services

- CT and PET scans
- MRI/MRAs
- Nuclear medicine scans

Get started

Find DDPs at **myuhc.com** or on the UnitedHealthcare® app

United Healthcare

Health Management | UnitedHealthcare Rewards

A wellness program built to inspire healthier habits

Welcome to UnitedHealthcare Rewards, where healthy choices may result in healthy savings.

It all starts with a few small steps

Participants track daily activities designed to help them move more and take healthy actions, with the potential of getting rewarded up to $1,000—depending on their plan.

What makes Rewards different?

Combining the best practices from our existing health and wellness incentive programs, Rewards goes a step further by:

- Offering a registration incentive for completing onboarding questions and pairing a device
- Adding wellness activities built for better sleep, regular exercise and taking other rewardable actions
- Integrating the UnitedHealthcare digital experience with the UnitedHealthcare® app, making it available at participants' fingertips

Getting rewards

With daily participation, there's a potential to earn up to:

- **$300*** with Rewards Core, including a $25 registration incentive
- **$1,000*** with Rewards Premium, including a $65 registration incentive

Redeeming rewards

Earnings can be deposited directly into health savings accounts or used toward:

- A Visa® gift card[1]
- Electronic devices and more

DENTAL BENEFITS

Administered by MetLife

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the City of Port Washington dental benefit plan.

SERVICES	IN-NETWORK AND OUT-OF-NETWORK PPO
Calendar Year Deductible	$0 per person; $0 family limit
Calendar Year Benefit Maximum	$1,500
Preventive Dental Services (cleanings, exams, x-rays)	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	100%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%
Orthodontia Services (Dependent children up to age 26)	50% to $1,500 lifetime maximum

VISION BENEFITS

Administered by MetLife

Regular eye examinations can determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone. Insured individuals are not required to see a provider in-network; however, the plan pays higher coverage levels for in-network services.

SERVICE	IN-NETWORK (ANY VISION SERVICE PLAN PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
Eye Exam — once every 12 months	$10 copay	Reimburse up to $45
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$25 copay	Reimburse up to $30
Lined Bifocal Lenses	$25 copay	Reimburse up to $50
Lined Trifocal Lenses	$25 copay	Reimburse up to $65
Frames — once every 24 months	$25 copay; Frames: $130 allowance plus 20% off; Featured frames: $150 allowance plus 20% off	Reimburse up to $70
CONTACT LENSES —ONCE EVERY 12 MONTHS IF YOU ELECT CONTACTS INSTEAD OF LENSES/FRAMES		
Allowance	$130 allowance	Reimburse up to $105
Medically Necessary	$25 copay	Reimburse up to $210
Separate Fitting Allowance	$60 allowance	Applied to the allowance for the contact lenses

Find a Vision Provider at:
www.metlife.com/vision

Download a claim form at:
www.metlife.com/mybenetits

For general questions go to:
www.metlife.com/mybenefits
or call 1-855-638-3931

SPENDING ACCOUNTS

New Administrator

FLEXIBLE SPENDING ACCOUNT

Administered by Associated Bank

You can save money on your healthcare and/or dependent daycare expenses with a Flexible Spending Account (FSA). The FSA allows you to set aside funds each pay period on a pre-tax basis and use them tax-free for qualified expenses. Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income. FSA contributions are deducted biweekly (26 paycheck per year).

Feature	Healthcare FSA	Dependent Care FSA
Maximum contribution per year	$3,200	$5,000
Can be used for eligible…	Medical, dental and vision expenses for you and your dependents	Daycare expenses for eligible dependents

SPENDING ACCOUNTS

New Administrator

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Administered by Associated Bank

The City of Port Washington is continuing a Section 105 Health Reimbursement Arrangement (HRA) to help provide better health care coverage to employees and their families. HRAs are implemented by many employers to help manage increasing health care costs and to provide employees with an incentive to be better consumers of health care. Qualifying expense are medical, dental, vision and OTC expenses.

	City's Annual HRA Contribution	Reimbursement Levels
Employee	$1,750	50% of the first $3,500 of eligible expenses, up to a maximum of $1,750
EE + Spouse **EE + Child(ren)** **Family**	$3,500	50% of the first $7,000 of eligible expenses, up to a maximum of $3,500.

Please note: any excess expenses above and beyond these limits are the responsibility of the employee.

LIFE INSURANCE BENEFITS

LIFE INSURANCE

Administered by Wisconsin Department of Employee Trust Funds

The City of Port Washington provides all full-time employees with life insurance. The benefit is equal to the employee's base annual salary rounded to the next highest $1,000 increment. Employees are enrolled in this coverage automatically, and it cannot be waived. The City pays the full annual premium for this coverage.

Voluntary Supplemental and Additional Life Insurance

Eligible employees may purchase additional amounts of life insurance through the Wisconsin Department of Employee Trust Funds. Additional purchase options include a Supplemental Plan at 1x the employee's base earnings and the Additional Plan at 3x the employee's base earnings. Premium rates vary based on age. Premiums are deducted from the first paycheck per month.

AGE	Under 30	30-34	35-39	40-44	45-49	50--54	55-59	60-64	65-69	70+
Rate	$0.05	$0.06	$0.07	$0.08	$0.12	$0.22	$0.39	$0.49	$0.57	$1.00+
Monthly rate per $1,000										

Voluntary Spouse/Dependent Life Insurance

Eligible employees may purchase life insurance for their spouse and dependents through the Wisconsin Department of Employee Trust Funds. The Spouse + Dependent Plan may be purchased in 1 or 2 units of coverage. Premium is deducted from the first paycheck per month.

Monthly Rates	1 Unit	2 Units
Spouse + Dependent	$1.60	$3.20

DISABILITY INSURANCE

DISABILITY INSURANCE

Administered by MetLife

This benefit replaces a portion of your income if you become disabled and are unable to work. Employees are enrolled in this coverage automatically, and it cannot be waived. The City pays the full annual premium for this coverage.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-Term Disability	You receive 60% of the first $1,667 of your predisability earnings of your income up to $1,000 per week. Benefits begin after 7 calendar days of absence from work for illness and 0 calendar days for injury and continue for up to 26 weeks.	Company
Long-Term Disability	You receive 60% of predisability earnings of your income up to $5,000 per month. Benefits begin after 180 calendar days or until short-term disability benefits end and continue until you reach the Social Security Normal Retirement Age (SSNRA).	Company

ACCIDENT and HOSPITAL INDEMNITY INSURANCE

ACCIDENT INSURANCE

Administered by MetLife

A voluntary accident plan through MetLife is available to eligible employees and their spouse/dependent children. For covered accidental injuries, fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more. Premiums are deducted from the first paycheck per month.

This plan includes a $50 per calendar year Health Screening Benefit.

Coverage Level	MONTHLY
Employee Only	$9.22
Employee + Spouse	$18.09
Employee + Children	$20.87
Family	$25.56

HOSPITAL INDEMNITY INSURANCE

Administered by MetLife

A voluntary hospital indemnity plan through MetLife is available to eligible employees and their spouse and dependent children. Hospital indemnity helps covered employees and their families cope with the financial impacts of a hospitalization. Fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. You can receive benefits when you are admitted to the hospital for a covered accident, illness or childbirth. Premiums are deducted from the first paycheck per month.

This plan includes a $50 per calendar year Health Screening Benefit.

Coverage Level	MONTHLY
Employee Only	$17.98
Employee + Spouse	$36.99
Employee + Children	$28.21
Family	$47.21

CRITICAL ILLNESS INSURANCE

CRITICAL ILLNESS INSURANCE

Administered by MetLife

A voluntary critical illness plan through MetLife is available to eligible employees and their spouse and dependent children. The plan provides a single cash benefit to you if you're diagnosed or treated for a covered critical illness event.

Your cost depends on how much coverage you select, your age as of the effective date. You will be offered $10K, $20K or $30K guaranteed issue coverage. Your Spouse/Domestic Partner will be offered 50% of your chosen benefit amount and your child(ren) will also be offered 50% of your chosen benefit amount. Premiums are deducted from the first paycheck per month.

This plan includes a $50 per calendar year Health Screening Benefit.

Monthly Premium for $1,000 of Coverage				
Attained Age	**Employee Only**	**Employee + Spouse**	**Employee + Children**	**Family**
<25	$0.66	$1.06	$0.98	$1.38
25–29	$0.70	$1.12	$1.02	$1.44
30–34	$0.92	$1.45	$1.24	$1.77
35–39	$1.06	$1.66	$1.38	$1.98
40–44	$1.25	$1.95	$1.57	$2.26
45–49	$1.85	$2.84	$2.17	$3.16
50–54	$2.69	$4.10	$3.01	$4.42
55–59	$3.83	$5.82	$4.15	$6.13
60–64	$5.23	$7.92	$5.55	$8.24
65–69	$7.24	$10.94	$7.56	$11.25
70+	$10.65	$16.04	$10.97	$16.36

EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR BENEFITS

The City contributes eighty-five (85) percent of the monthly medical insurance premium. The additional fifteen (15) percent is the responsibility of the employee. Premiums are deducted from the first two paychecks per month.

BENEFIT PLAN	MONTHLY	PER PAYCHECK
Medical/Rx		
Employee	$89.24	$44.62
Employee + One	$178.49	$89.24
Employee + Child(ren)	$169.56	$84.78
Family	$285.58	$142.79

The City contributes seventy-five (75) percent of the monthly dental insurance premium. The additional twenty-five (25) percent is the responsibility of the employee. Dental and Vision Premiums are deducted from the first two paychecks per month.

BENEFIT PLAN	MONTHLY	PER PAYCHECK
Dental Rates		
Employee	$11.03	$5.52
Employee + One	$24.82	$12.41
Employee + Child(ren)	$24.82	$12.41
Family	$34.47	$17.24

BENEFIT PLAN	MONTHLY	PER PAYCHECK
Voluntary Vision Rates		
Employee	$7.01	$3.51
Employee + One	$14.05	$7.03
Employee + Child(ren)	$11.90	$5.95
Family	$19.61	$9.81

PENSION, 457(B) AND EAP

WISCONSIN RETIREMENT SYSTEM PENSION PLAN

Administered by Wisconsin Retirement System (WRS)

The City of Port Washington participates in the WRS. The WRS was created to protect public employees and their beneficiaries against the financial hardships of old age and disability and to attract and retain a qualified public workforce. WRS covers all employees who work at least 1200 hours in the calendar year.

The WRS offers a retirement benefit based on a defined contribution plan or a defined benefit plan. A defined contribution plan means there is a set amount of money (that may change each year) paid into a member's retirement account. Half of this amount is deducted from the employee's paycheck and half is paid (matched) by the employer. A defined benefit plan means that the amount paid to you in retirement is based on a formula that is fixed, and therefore "defined." For 2024, general employee contributions will equal 6.9% with a matching 6.9% paid by the City. Protective employee contributions will equal 6.9% with an additional 14.2% paid by the City.

457(B) DEFERRED COMPENSATION PLAN

The City of Port Washington offers full-time employees the opportunity to participate in a 457(b) Deferred Compensation Plan. Employees may choose to contribute on a flat dollar amount or percentage basis. Federal contribution limits cap-out at $23,000 for 2024. The City partners with multiple vendors to administer the plan including Wisconsin Department of Employee Trust Funds, ICMA's MissionSquare Retirement, and North Shore Bank.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by MetLife LifeWorks Program

The City offers all employees access to the Employee Assistance Program (EAP). EAP services include guidance from professional experienced counselors that offer free and confidential support 24/7/365 for employees struggling with personal or work-related concerns.

Help with:

- Balancing work and life
- Stress and anxiety
- Finding child or elder care
- Loss of a loved one
- Family, marital and relationship challenges
- Legal issues
- Financial issues.

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	UnitedHealthcare	866.673.6293	myuhc.com
Dental	MetLife	800.942.0854	metlife.com/mybenefits
Vision	MetLife	855.638.3931	metlife.com/mybenefits
Flexible Spending Account	Associated Bank	800.270.7719	associatedbank.com
Life and AD&D	Wisconsin Department of Employee Trust Funds	877.533.5020	etf.wi.gov/benefits_life_ins.htm
Short Term Disability	MetLife	800.638.2242	metlife.com/mybenefits
Long Term Disability	MetLife	800.638.2242	metlife.com/mybenefits
Accident	MetLife	800.438.6388	ahmetlifeclaims@metlife.com
Hospital Indemnity	MetLife	800.438.6388	ahmetlifeclaims@metlife.com
Critical Illness	MetLife	800.438.6388	ahmetlifeclaims@metlife.com
Employee Assistance Program (EAP)	MetLife	888.319.7819	metlifeeap.lifeworks.com
Assistant City Administrator/HR Director	Emily Blakeslee	262.284.5585 x 1003	eblakeslee@portwashingtonwi.gov

LEGAL NOTICES

PATIENT PROTECTIONS DISCLOSURE

The City of Port Washington Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, UnitedHealthcare designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the UnitedHealthcare at 866.673.6293 or myuhc.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the UnitedHealthcare at 866.673.6293 or myuhc.com.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

Plan 1: Choice Plus HDHP (Individual: 10% coinsurance and $3,500 deductible; Family: 10% coinsurance and $7,000 deductible

If you would like more information on WHCRA benefits, please call your Plan Administrator at 262.284.5585 x 1003 or eblakeslee@portwashingtonwi.gov.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

LEGAL NOTICES

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

LEGAL NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

LEGAL NOTICES

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP)Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

LEGAL NOTICES

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

LEGAL NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
City of Port Washington is committed to the privacy of your health information. The administrators of the City of Port Washington Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Emily Blakeslee - Assistant City Administrator/ HR Director at 262.284.5585 x 1003 or eblakeslee@portwashingtonwi.gov.

HIPAA SPECIAL ENROLLMENT RIGHTS

City of Port Washington Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Port Washington Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Emily Blakeslee - Assistant City Administrator/HR Director at 262.284.5585 x 1003 or eblakeslee@portwashingtonwi.gov.

LEGAL NOTICES

NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Port Washington

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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 Port Washington coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current City of Port Washington coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Port Washington and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Port Washington changes. You also may request a copy of this notice at any time.

LEGAL NOTICES

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**January 01, 2024**
Name of Entity/Sender:	**City of Port Washington**
Contact—Position/Office:	**Emily Blakeslee - Assistant City Administrator/HR Director**
Office Address:	**100 W Grand Ave, PO BOX 307** **Port Washington, WI 53074-2217** **United States**
Phone Number:	**262.284.5585 x 1003**

LEGAL NOTICES

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** 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."

LEGAL NOTICES

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 *City of Port Washington*, 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. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;

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: Emily Blakeslee.

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.

LEGAL NOTICES

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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

City of Port Washington
Emily Blakeslee - Assistant City Administrator/HR Director
100 W Grand Ave, PO BOX 307
Port Washington, WI 53074-2217
United States
262.284.5585 x 1003

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start .

LEGAL NOTICES

MARKETPLACE NOTICE

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 credit.[2]

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 Emily Blakeslee.

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.

[2] 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.

NOTES

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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