Benefits Annual Compliance Addendum

2022

Madison Metropolitan School District

Important Notice from Madison Metropolitan School District 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 the Madison Metropolitan School District 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. The Madison Metropolitan School District has determined that the prescription drug coverage offered by the Dean HMO, Dean POS, Dean PPO, GHC HMO, GHC POS and GHC PPO plans are, 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 Dean HMO, Dean POS, Dean PPO, GHC HMO, GHC POS and GHC PPO plans coverage may be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Madison Metropolitan School District health insurance coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

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 the Madison Metropolitan School District 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 at (608) 663-1692. 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 the Madison Metropolitan School District changes. You also may request a copy of this notice at any time.

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:	July 1, 2021
Name of Entity/Sender:	Madison Metropolitan School District
Contact--Position/Office:	Benefits@madison.k12.wi.us
Address:	545 W. Dayton St, Madison, WI 53703
Phone Number:	(608) 663-1692

CMS Form 10182-CC Updated April 1, 2011

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

Compliance Information

The administration of the Plan is under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily or capriciously.

The following pages outline those Plan specifications that vary between the different benefit programs established as part of the Madison Metropolitan School District Insurance Plan.

The benefits identified on the attached Schedule A are provided pursuant to insurance contracts and/or Plan documents between the Plan Administrator and the Insurer or Contract Administrator. If the terms of this summary plan document conflict with the terms of the Plan document and/or Certificate of Coverage,

the terms of the insurance contract and/or Plan document will control, unless superseded by applicable law. For further information about these Plan benefits refer to the Plan document or Certificate of Coverage for each separate benefit outlined in Schedule A, or contact the Plan Administrator.

Description on Types of Funding Arrangements

Fully-insured Plan: In a fully-insured Plan, benefits are provided under a group insurance contract entered into between the Plan Administrator and the Insurer. Claims for benefits are sent to the insurance company. The insurance company, not the Plan Administrator, is responsible for paying claims and for the financial risk of paying claims under the Plan. (However, the insurance company and the Plan Administrator share the responsibilities of administering the Plan.) Insurance premiums for Plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Plan Administrator out of the general assets of the Employer, as needed.

Self-insured Plan: In a self-insured Plan or partially self-insured Plan, the Plan Administrator hires the Contract/Claims Administrator to process claims under the Plan. The Contract/Claims Administrator does not serve as an Insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract/Claims Administrator. The Contract/Claims Administrator processes the claims, then requests and receives funds from the Plan Administrator to pay the claims and make payment on the claims to health care providers. The Plan Administrator is ultimately responsible for providing Plan benefits, not the Contract/Claims Administrator. If the Plan is partially self-insured, the insurance company and the Plan Administrator share responsibility for administering the Plan. There is no special fund or trust or insurance from which benefits are paid. Employee contributions (pre-tax and after-tax, as applicable) are also paid by the Plan Administrator out of the general assets of the Employer, as needed.

Special Information Regarding a Section 125 Plan

The Plan Administrator has established a "cafeteria plan" under Internal Revenue Code Section 125, which allows employees to pay for medical, dental and vision coverages on a pre-tax basis. If an employee elects to enroll in the cafeteria plan, the employee must sign an enrollment form agreeing to have employment salary reduced by an amount equal to the applicable share of the premiums for the coverages elected. An employee's salary reduction amount is not included in taxable income for purposes of federal and most state and local income taxes. Social Security tax is also not paid, which means contributions may reduce wages reported for Social Security purposes and could ultimately reduce an employee's Social Security benefit amount.

If the employee is enrolled in the cafeteria plan, reduced salary elections will be effective for the entire Plan year. Salary reductions cannot be changed during the Plan year, unless an allowable change event occurs, as defined in the Section 125 plan document. Examples of allowable change events include marriage, divorce, birth or adoption of a child, death of a spouse or child, loss of coverage under another employer's Plan due to termination of employment, change in employment status resulting in gain or loss of eligibility for coverage, or changes in cost or coverage.

ELIGIBILITY AND BENEFIT TERMINATION SPECIFICATIONS

Eligibility Requirements

This Summary Plan Description (SPD) and Plan document is issued in conjunction with corresponding Certificates of Coverage or insurance contracts for each of the Plans identified on the attached Schedule A. Information regarding eligibility requirements can be found in the specific document describing each separate benefit. Plan participants must complete an enrollment application (provided by the Plan Administrator) in a timely fashion in order to receive or be eligible for certain benefits.

Benefit Termination

This SPD and Plan document is issued in conjunction with corresponding Certificates of Coverage or insurance contracts for each of the Plans identified on the attached Schedule A. Information regarding loss of benefits and when benefits terminate can be found in the Certificates of Coverage or the Insurance Contracts describing each separate benefit.

STATEMENT OF RIGHTS

Plan participants have the following rights and protections as a participant in your Employer's employee benefit Plan.

Right to Examine Plan Documents

Plan participants have the right to examine all documents governing the Plan, including insurance contracts and any latest annual reports. The Plan Administrator will tell the Plan participant where the Plan documents are available for examination. Plan participants may examine any documents without charge.

Right to Obtain Copies of Plan Documents

Plan participants have the right to obtain copies of all Plan documents and other Plan information upon written request, including insurance contracts/Plan documents and any annual reports and an updated Summary Plan Description. The Plan Administrator may request a reasonable charge for the copies.

Right to Receive a copy of Annual Report

The Plan Administrator must furnish to Plan participants a copy of the Plan's summary annual financial report, if the Plan is required to file an annual report. There will be charge for the full annual report.

Right to Written Explanation of Denial

If a Plan participant's claim for benefits under the employee benefit Plan is denied or ignored, in whole or in part, a Plan participant has a right to obtain a written explanation for the reason for denial, and to obtain copies of documents related to the decision without charge.

Right to Review

Plan participants have the right to appeal any welfare benefit denial and have the Plan Administrator review and reconsider any denial of a participant's claim for Plan benefits.

Claim Review

Plan participants have the right to have the Plan review and reconsider a claim. There are steps participants can take to enforce the above rights. Plan participants the right to file suit in a state or federal court if your claim for benefits under the employee benefit Plan is denied or ignored. A Plan participant can also file suit in a federal court if you request Plan documents and do not receive them within 30 days. In such a situation, the court will require the Plan Administrator to give the participant the Plan documents requested. In some cases the court could also require the Plan Administrator to pay the Plan participant a monetary penalty per day until you receive the requested materials, unless the materials were not sent because of reasons beyond the control of the administrator. In addition, if you disagree with the Plan's decision (or lack thereof) concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

Assertion of Rights

If it should happen that the fiduciaries have misused the Plan's money or assets, or that you have been discriminated against for asserting your rights, you can ask for help from the U.S. Department of Labor. You can also file suit in a federal court. If you file a suit, the court will decide who must pay those costs and legal fees. If you are successful, the court may order the person you have sued to pay those fees. If you lose, the court may order you to pay those costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

TERMINATION/MODIFICATION/AMENDMENT TO THE PLAN

The Plan Administrator has the right to amend or terminate the Plan or any element of the Plan at any future time. No consent of any participant is required to terminate, modify, amend or change the Plan. Your individual coverage terminates at the earliest of the following conditions:

- When you leave your employment;
- When you are no longer eligible;
- When you cease to contribute (if the Plan is contributory);
- When the Plan terminates.

The Plan Administrator may enter into contracts with a Contract/Claims Administrator to provide coverage or provide administrative services. The Plan Administrator has the right to amend, terminate, modify or change any element of the Plan, or any relationship with a Contract/Claims Administrator at any time with prior written notice.

Other Provisions

If you cease employment, your individual Certificates of Coverage or other applicable Plan documents will determine what arrangements, if any, may be made to continue your coverage beyond the date you cease employment.

A Contract/Claims Administrator may terminate coverage or other administrative services if the Plan Administrator fails to pay the required premium in a timely manner as prescribed by the contract. A Contract/Claims Administrator may also terminate the Insurance Contract on any premium due date if the number of persons insured is less than the minimum number required, or if the Plan Administrator fails to meet any criteria under the Insurance Contract.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

According to the Consolidated Omnibus Budget Reconciliation Act (COBRA) you and your eligible dependents may elect to temporarily continue group medical, dental, vision, Section 125 Plan coverage under certain circumstances if you lose benefits.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child'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: Madison Metropolitan School District.

How is COBRA 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 spouse, and parents may elect COBRA continuation coverage on behalf of their children.

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

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops

being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options beside 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, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at 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

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

Plan Contact Information

Madison Metropolitan School District
545 West Dayton Street
Madison, WI 53703
(608) 663-1795

Plans Not Subject to COBRA

Life insurance and disability benefits are not subject to COBRA continuation provisions. However, in certain circumstances an existing life or disability insurance conversion period may be exercised within a specified period of time following the date of termination. If a Plan participant wishes to learn more about a conversion policy and whether one is available, Plan participants should refer to the Certificate of Coverage for specific requirements.

SPECIAL ENROLLMENT PERIODS

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which a group health Plan may exclude coverage for medical conditions present before an individual enrolled.

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. However, you must request enrollment within 30 days after your or your dependents' other coverage end (or after the employer stops contributing toward the other coverage). Coverage will begin retroactive to the date the other coverage terminated.

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 add coverage under these circumstances, you may add coverage mid-year. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If you were or your dependent was:

- covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
- becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. You must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

MICHELLE'S LAW NOTICE

If you have a dependent older than age 18 who is enrolled at a post-secondary institution (e.g., college or university) on a full-time basis, he or she may be eligible to continue to be covered as a dependent if he or she loses full-time student status due to a serious injury or illness. In order to be eligible to continue coverage as a dependent under Michelle's Law:

- the dependent child must be enrolled in the medical plan based on full-time student status immediately before the first day of the medically necessary leave of absence;
- a doctor's written certification of the medically necessary leave of absence must be submitted to the health insurance company; and
- proof of full-time student status before the leave of absence may also be required to be submitted to the health insurance company.

Continued dependent coverage will be extended for at least one year after the first day of the leave of absence, but may end earlier if the dependent child does not meet the dependent eligibility requirements under the medical plan, such as meeting the limiting age for dependent eligibility under the plan. If dependent coverage under Michelle's Law ends, the dependent may be eligible for continuation coverage under the provisions of the medical plan.

If an eligible dependent remains enrolled in the medical plan, under Michelle's Law, the dependent child will continue to be in the same medical benefit options that he or she was in prior to the medical leave of absence.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

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

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and/or coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

MATERNITY COVERAGE LENGTH OF HOSPITAL STAY

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may 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).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled. The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if the absence during military duty would result in a loss of coverage as a result of active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee and covered dependents will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

BENEFITS DURING FAMILY MEDICAL LEAVE

When required by law, our benefit program will comply with the Family and Medical Leave Act (FMLA) requiring continuation rights for health coverage, assuming the Plan Administrator meets certain criteria during the preceding calendar year. If the Plan Administrator is subject to the law, and you are covered under health benefit Plans, you may be eligible to continue the coverage under our benefit Plan for a certain period of time.

To the extent required under the FMLA, and the regulations thereunder, an employee on leave of absence under the FMLA may choose to continue coverage under the Plan by making the applicable contributions, on an after-tax basis, in accordance with procedures established by the Plan Administrator that are consistent with the FMLA. In addition, to the extent required under and in accordance with the FMLA and the regulations thereunder, any employer contributions made under the terms of the Plan shall continue to be made on behalf of an employee on the FMLA leave.

Contact Human Resources for additional information on the FMLA leave policy or if you want to request leave. You may also have certain rights under other state family leave laws.

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado
(Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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

CHIP (continued)

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – 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

LOUISIANA – Medicaid
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
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – 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

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

CHIP (continued)

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

CHIP (continued)

To see if any other states have added a premium assistance program since July 31, 2021, 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 1/31/2023)

CLAIMS PROCEDURES

Right to Appeal a Denied Claim

For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the applicable Certificate of Coverage or Plan document for each of the separate benefit Plans. The following is a general overview of the basic requirement for appealing claims.

If a Plan participant's claim under the medical, dental, or vision Plan is denied in whole or in part, the Plan participant will be notified in writing by the Claims Administrator or Insurer for that benefit Plan.

Claim Denials

If a claim for benefits is wholly or partially denied, any notice of an adverse benefit determination under the Plan will:

- State the specific reasons for the determination;
- Reference the specific Plan provision(s) on which the determination is based;
- Describe additional material or information necessary to complete the claim and why such information is necessary;
- Describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court;
- Disclose any internal rule, guidelines, protocol or similar criteria relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- If the denial is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- A description of appropriate information as to the procedures and steps required so you can submit the claim for appeal.

If you do not agree with the claim denial, you may request that a review of the claim be made. The claim denial will inform you of the address of the agency to whom written request may be made for the review. You may submit additional information for review. You may request and receive copies of relevant documents, although in some cases approval may be needed for release of confidential information such as medical records. Such relevant documents may be provided to you free of charge. Issues and comments may be submitted in writing. You have up to 180 days to submit an appeal. A decision will be made within 45 days (medical and dental related claims) or within 60 days (for non-health claims) of receipt of the request for review, assuming all the requested claim information has been provided to the Claims Administrator or Insurer. Notification of the decision will specify the reasons for the decision and will be written in a manner intended to be understood by the claimant.

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

If you have any questions about this Notice, please contact the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703.

This Notice is effective on July 1, 2016.

Our Commitment Regarding Your Personal Health Information

The Madison Metropolitan School District is committed to maintaining and protecting the confidentiality of our employees' personal information. This Notice of Privacy Practices applies to the Madison Metropolitan School District insurance plans covered by the privacy regulations (collectively, the Plans). The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. When the Plans use or disclose your PHI, the Plans are bound by the terms of this Notice, or the revised Notice, if applicable.

How We May Use And Disclose Medical Information About

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. If you have any questions about this notice, please contact the Director of Benefits at the Madison Metropolitan School District at (608) 663-1795.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim

of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses And Disclosures That Require Us To Give You An Opportunity To Object And Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your Written Authorization Is Required For Other Uses And Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703.

Changes To This Notice
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Director of Benefits, Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

You may contact our office at:
Madison Metropolitan School District, Human Resources Department
545 West Dayton Street
Madison, WI 53703

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.

403(b) PARTICIPATION ANNUAL NOTICE

The Madison Metropolitan School District offers all eligible employees the opportunity to save for retirement by participating in the 403(b) Retirement Savings Plan (the "403(b) plan"). You are eligible to participate in this plan, whether or not you are actively contributing to it. You can participate in this plan beginning on your date of hire and can make contributions through pre-tax contributions and Roth 403(b) after-tax contributions.

Not Contributing
To start your contributions to the 403(b) plan, complete and return a salary reduction agreement to the Benefits Division.
Please note that in addition to completing and returning a salary reduction agreement, you must also establish an account with the appropriate investment provider(s) that you have selected on the salary reduction agreement and you may also need to provide any additional information that may be required to enroll you in the 403(b) plan.

Already Contributing
If you are already currently contributing to the 403(b) plan, you may be able to increase your pre-tax contributions and Roth 403(b) after-tax contributions. To change your contributions, complete and return a salary reduction agreement to the Benefits Division.

You can keep your contributions at their current level. In the alternative, if your current financial situation means that you need to lower your saving for retirement, you can change your contribution rate by completing and returning a salary reduction agreement as described above.

How Much Can I Contribute?
The Internal Revenue Code limits the annual contributions you can make to a 403(b) plan and the limits are adjusted each year. The 2020 limits are as follows:

- Effective deferral limit: $19,500
- Age 50 catch-up: $6,500

- 15 years of service catch-up: $3,000

More Information
To learn more about 403(b) plans, please visit www.irs.gov and search for Publication 571. If you have any questions about how the plan works or your rights and obligations under the plan, please contact the Director of Benefits at the Madison Metropolitan School District, 545 West Dayton Street, Madison, WI 53703.

This Notice is not intended as tax or legal advice. Neither your employer nor the investment providers offering retirement savings products under the plan can provide you with tax or legal advice. Employees are encouraged to contact their financial representative or tax professional with any questions

415 NOTICE: 403(b) AGGREGATION OF MAXIMUM CONTRIBUTION LIMIT WHEN YOU CONTROL ANOTHER EMPLOYER

MADISON METROPOLITAN SCHOOL DISTRICT 403(B) PLAN
Federal law limits the total amount that may be contributed on your behalf to this 403(b) plan and any other retirement plan. The contributions to other retirement plans may need to be aggregated with contributions to this 403(b) plan to verify the maximum annual limit is not exceeded. This notice informs you of your responsibility to provide information to the Plan Administrator regarding your control or ownership of other entities that maintains a plan in which you participate. **Failure to provide necessary and correct information to the Plan Administrator could result in adverse tax consequences for you.** Contributions to this 403(b) plan will be aggregated with one or more defined contribution plans if you are deemed to control the employer sponsoring such plans. For aggregation purposes, you are deemed to control a for-profit employer if you own more than 50% (including attribution from others) of its:

- Shares,
- Capital interests,
- Profit interests, or
- Membership interests.
- You are deemed to control a tax exempt organization if you have control over its directors or trustees. A defined contribution plan includes:
- Plan qualified under Code section 401(a) or 403(a) (e.g., 401(k) plan),
- Code section 403(b) plan, and
- Simplified Employee Pension (SEP) within the meaning of Code section 408(k).

For illustration purposes, suppose you own a separate business which adopts a 401(k) plan. For 2019, you elect to defer up to the maximum 403(b) dollar amount of $19,500 and make a catch-up contribution of $6,500. Your employer also made a non-elective employer contribution of $37,000 to the 403(b) plan on your behalf. You would like to contribute $15,000 to the 401(k) plan of your separate business for the 2020 year. Your compensation from your employer is $100,000 and compensation from your separate business is $60,000. The catch-up contribution is not counted toward the maximum annual limit. The total elective and non-elective contributions to the 403(b) plan are $56,500 ($37,000 + $19,500) which equals the maximum annual limit for 2020. Therefore, any contributions to your 401(k) plan (e.g. $15,000) would exceed the maximum annual limit on an aggregate basis. If you were to contribute $15,000 or any amount to the 401(k) plan for the 2019 year, the amount would be considered an excess annual addition attributable to the 403(b) plan. **For this reason, it is critical you provide any control or ownership information for other entities to the 403(b) plan administrator.**

The plan administrator will coordinate with you to ensure satisfaction of the maximum annual limit for contributions to all retirement plans. Please contact the plan administrator to provide any pertinent information on control or ownership of other entities or to address any of your questions.

NOT AN EMPLOYMENT CONTRACT

None of the Plans or benefits discussed on the preceding pages are to be considered contracts for employment between the Employee and the Employer. The Plans do not guarantee the Employee the right of continued employment nor do they limit the Employer's right to discharge the Employee.

SCHEDULE A PLAN BENEFITS

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services, including as Contract/Claim Administrators. These services include administering claims and providing customer service.

Type of Plan	Type of Funding	Contribution
Medical Plans *Dean Health Plan* PO Box 56099 Madison, WI 53705 1-800-279-1301 www.deancare.com	Fully-Insured	Employer and Employee Contributions
Group Health Cooperative of South Central Wisconsin 1265 John Q Hammons Drive, Suite 200 Madison, WI 53717 1-800-605-4327 www.ghcscw.com	Fully-Insured	Employer and Employee Contributions

Dental *Delta Dental of WI* P.O. Box 828 Stevens Point, WI 54481 800-236-3712 www.deltadentalwi.com	Self-Insured	Employer and Employee Contributions
Vision *Delta Dental of WI / EyeMed* P.O. Box 828 Stevens Point, WI 54481 800-236-3712 www.deltadentalwi.com	Fully-Insured	Employee Contributions
Life Insurance *The Standard* P.O. Box 711 Portland, OR 97207 1-800-348-3226 www.standard.com	Self-Insured	Employer and Employee Contributions
Supplemental Life *The Standard* P.O. Box 711 Portland, OR 97207 1-800-348-3226 www.standard.com	Self-Insured	Employee Contributions
Long Term Disability/Short Term Disability *The Standard* P.O. Box 711 Portland, OR 97207 1-800-348-3226 www.standard.com	Fully-Insured	Employer Contributions / Employee Contributions
Section 125 Plan (Health Care and Dependent Care FSA) EBC Flex 1250 Deming Way, Suite 300 Madison, WI 53562 1-800-346-2126 www.ebcflex.com	Self-Insured	Employee Contributions
Employee Assistance Program *BDA* 877-851-1631 www.eapbda.com	N/A	N/A

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private 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. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURNACE 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 are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our 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 self-only coverage under our health plan is more than 9.69% of your household income for the year, or if our health plan does not meet the "minimum value"[1] standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – 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 ABOUT THE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. You can 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.

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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.

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name:
Employer Identification Number (EIN):
Employer Address:
Employer Phone Number:
Who can we contact about employee health coverage at this job? Phone Number (if different from above): E-mail address:

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.
- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.
- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.
- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.
- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.
- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.