

City of Manchester Plan Document and Summary Plan Description

About Your Participation and Key Administrative Information

About Your Participation	1
Who is Eligible	1
Enrolling for Coverage.....	3
Changing Your Elections During the Year.....	3
Paying For Your Medical Coverage	8
When Coverage Begins.....	8
What Happens During a Leave of Absence	9
When Coverage Ends	11
Applying for Continued Health Care Coverage Under COBRA	11
Address Changes	17
For More Information	17
Administrative Information	18
No Continued Right to Employment	18
HIPAA Information.....	18
Genetic Information Non-discrimination Act of 2008 (GINA).....	19
How Benefits Can Be Forfeited or Delayed.....	19
Compliance With Federal Law.....	19
Ownership of Benefits	19
Subrogation and Third-Party Reimbursement.....	20
Divorce and Your Plan Benefits.....	21
Plan Administration.....	22
Future of the Plans	23
Plan Facts	24
HIPAA Privacy & Security Rule Addendum	25
Permissible Uses and Disclosures	25
Electronic Health Information	27

This document and the contracts for each of the Medical Plans covered hereunder (the “Contracts”) together constitute the plan document and Summary Plan Description for the City of Manchester Health & Welfare Plan (the “Plan”). The Plan is an “employee welfare benefit plan,” and in part, a “cafeteria plan” under the Internal Revenue Code of 1986, as amended.

This document describes the rules for participation in the Plan. It also contains information to which you are legally entitled as a plan participant, and summarizes the eligibility and Plan administration rules of the Plan. For more information about the particular benefits to which you may be entitled, please refer to those individual Contracts for details. To the extent any information contained in this document is inconsistent with the Contracts, the Contracts shall govern.

The City of Manchester (the “City”) is the plan sponsor and the plan administrator of the Plan (the “Plan Administrator”).

About Your Participation

Who is Eligible

You must be an employee of the City of Manchester, or a dependent of such employee and meet the applicable eligibility requirements in order to participate in the Plan.

Employees. You are eligible to participate if you are a regular full-time employee on the payroll of the City of Manchester and regularly scheduled to work at least 40 hours per week.¹

You are not eligible to participate in the Plan if you are:

- An independent contractor or a temporary or leased employee
- Not treated as a common law employee on the City of Manchester's payroll records, even if a court or administrative agency subsequently determines you are a common law employee
- A member of any other special classification of employees that is not eligible, as determined by the City of Manchester.

Dependents of employees. As long as you enroll as an employee, you may extend Medical coverage to your eligible dependents. Your eligible dependents are generally defined as your:

- Lawful spouse or civil union partner
- Each child of you, your spouse (or civil union partner) through the date each child reaches age 26 (including stepchildren, foster children and adopted children, and those for whom you are the court-appointed guardian).

A child is considered legally adopted from the start of any waiting period prior to the finalization of the child's adoption; a newly born infant is considered legally adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption.

Note: Coverage for an unmarried child with a mental or physical handicap who is dependent on you for more than one-half of his/her support can continue to be covered without regard to age. Proof that the disability began before your child's 19th birthday, or if older, while covered as a dependent under the Plan, will be required.

In addition, the Plan may cover a child of yours in accordance with a Uniform Support Order (USO), to the extent that the USO does not require coverage not otherwise offered under this Plan. The Plan Administrator (or its designee) will notify you if a medical child support order has been received and will notify both you and the affected child once a determination has been made. See "**Divorce and Your Benefits**" on page 21 for more information about a USO.

¹ **Note:** Full-time school LPNs working at least 37.5 hours per week, part-time LPNs at the Health Department working at least 20 hours per week and the elected City Alderman are also eligible to participate in the Plan.

When both husband and wife work for the City of Manchester. If you and your spouse (civil union partner) both work for the City of Manchester, you may each enroll as employees, or one of you can enroll as a dependent of the other. In either case, children can only be enrolled under one parent's coverage. If either spouse (civil union partner) works for the school district, you may each enroll as employees, or one of you can enroll as a dependent of the other. In either case, children can only be enrolled under one parent's coverage.

Proof of dependent eligibility. The City of Manchester requires that all eligible employees enrolling in the Plan provide documentation (marriage license, for example) to validate the eligibility of their enrolled dependent(s) within 30 days of enrolling in the Plan. The City of Manchester may also periodically require proof of continued eligibility for a dependent.

If you fail to provide all of the required documentation within 30 days of enrolling in the Plan, the City of Manchester will terminate your enrolled dependents' coverage under the Plan whether or not they are eligible for benefits under the Plan. The City of Manchester also reserves the right to terminate enrolled dependents' coverage under the Plan for failing to provide required documentation at any time when requested.

Important Note Regarding Retiree Medical Coverage

Employees under age 65 who retire from the City of Manchester may continue Medical Plan coverage for themselves and their eligible dependents provided they pay the full monthly premium. Active employee contributions for Medical Plan coverage would continue through the last day of the month in which they are employed; retiree contributions (100% of total premium) would begin on the first of the month of their retirement. In certain cases, you may be eligible for a medical subsidy from the state retirement or city retirement plans, which can help offset the full cost of the premium.

When a retiree (or retiree's spouse or civil union partner) turns age 65, he or she has the option to enroll in the Plan offered by the City for retirees over age 65. The Plan becomes effective the first of the month in which he or she turns age 65. The retiree (or retiree's spouse or civil union partner) would also be required to enroll in Medicare Part B.

For more information about retiree health care coverage and eligibility requirements, please contact the Human Resources Benefits Coordinator at **1-603-624-6543**.

Enrolling for Coverage

Participation in Medical Plan coverage is not automatic; you must enroll in order to have coverage in place. When you are first hired, you will receive information outlining the Medical Plan options available to you, the cost per pay period for each option, enrollment instructions, and the due date by which your election(s) must be recorded.

It is important for you to know that if you do not enroll by the due date you will be considered to have declined Medical coverage for the remainder of the plan year. The next opportunity you will have to enroll is during the next annual enrollment period, unless you have a qualified change in status or “**HIPAA Special Enrollment Event**” as explained in “**Changing Your Elections During the Year.**”

During annual enrollment. Each spring, the Plan Administrator will announce the open enrollment period during which time you will have an opportunity to change your Medical Plan election. Elections made during annual enrollment go into effect on July 1 and stay in effect for that entire fiscal year, unless you have a qualified change in status during the year (see “**Changing Your Elections During the Year**”) and you elect to make a change to your elections.

Changing Your Elections During the Year

The Plan Administrator will allow you to make changes to your elections each year during the annual open enrollment period with benefit elections becoming effective July 1. Outside of the annual enrollment period held each spring, changes to your benefit elections are restricted to those required as a result of a “qualified status change” as defined under IRS regulations.

What is a Qualified Change in Status Under Internal Revenue Code Section 125? The following events allow you to make changes to your Medical Plan coverage outside of the annual open enrollment period.

- A change in your legal marital status (for example, marriage, divorce, death of a spouse (civil union partner), legal separation, or annulment);
- A change in your number of eligible dependents due to birth, adoption, placement for adoption, appointment of legal guardianship, death, or when a dependent newly satisfies (or no longer continues to satisfy) the Plan’s dependent eligibility rules;
- A change in your, your spouse’s (civil union partner’s) and/or your dependent’s employment status, *but only if it affects your current elections*; for example, your beginning or ending employment, a reduction or increase in your hours that affects your eligibility, starting or returning from an unpaid leave of absence;
- A change in residence for you, your spouse (civil union partner), and/or your dependent, *but only if it affects your current elections*;
- You are served with a Uniform Support Order (USO);
- You, your spouse (civil union partner), and/or dependent become eligible for Medicare or Medicaid;
- Change in coverage under another employer’s plan;
- Change to other group health coverage for you, or your eligible dependents losing coverage under any government and/or educational institution sponsored group health plan.

Permissible types of benefit changes. Any change to your election(s) must be due to (and consistent with) your change in status. For example, if you have a baby during the year, you would be permitted to change your coverage option (e.g., from “Employee only” to “Two Person”). If you were to divorce, you must drop your ex-spouse’s coverage however, you would not be able to change your coverage election (e.g., from an HMO to POS). See the “**Life Status Coverage Changes**” chart for more information.

Who determines what’s permissible. The Plan Administrator (in its sole discretion) may determine whether your change in status is a qualifying event under the IRS regulations. The Plan may apply any change in status rule on a case-by-case basis in a uniform and consistent manner and without discrimination, and to the terms of any applicable insurance policy, where applicable. The application (or failure to apply) a change in status rule will neither limit nor prohibit the Plan Administrator’s right to apply the rule on any subsequent occasion.

Initiating a change. You have 30 days from your qualifying change in status to modify your elections and submit your completed enrollment change and proof of status change documentation to your payroll clerk or HR Department. If you are initiating a change due to loss of coverage, your enrollment change form and documentation must be received within 60 days of the date of coverage loss.

Do not delay in submitting your completed enrollment request. Late notifications will only be accepted and processed during the next annual open enrollment period, or if you experience another qualified change in status (whichever comes first).

Effective dates of coverage for changes. In most cases, once the Plan Administrator approves your request to change coverage, it becomes effective in accordance with guidelines for life status changes. However, in the case of a birth, adoption order, or placement for adoption, the effective date for the benefit election change will be retroactive to the day of the event (e.g., birth, adoption).

The following chart provides an overview of qualifying change in status events and the mid-year elections permissible under the Plan for the related change in status event.

Status Change	Permissible Elections
Marriage or civil union	Enroll, increase level and/or change plan
Divorce, legal separation or annulment	Decrease level of coverage, or enroll self or dependents if HIPAA special enrollment rights apply (<i>see page 6</i>)
Add a dependent child	Enroll, increase or decrease level of coverage and/or change plan
Death of a spouse or civil union partner	Decrease level of coverage, enroll self or dependents if HIPAA special enrollment rights apply (<i>see page 6</i>)
Death of a child	Decrease level of coverage and/or change plan
Dissolution of a civil union	Decrease level of coverage
Gain coverage through spouse or civil union partner plan	Decrease or cancel coverage; change level of coverage
Gain coverage through Medicaid or Medicare	Decrease or cancel coverage
Lose coverage through spouse's (civil union partner's) plan	Enroll for any plan and level or increase level of coverage in current plan
Lose coverage through Medicaid or Medicare	Enroll for any plan and level or increase level of coverage in current plan
If your spouse (civil union partner) has a mid-year annual enrollment	Enroll, increase or decrease level of coverage in current plan, or cancel coverage
Child no longer eligible	Decrease level of coverage
Change from full-time or part-time with benefits to part-time <i>without benefits</i>	Cancel coverage
Change from part-time without benefits to full-time or part-time <i>with benefits</i>	Enroll
Increase in cost of coverage, a reduction in coverage, or a new plan option added	Decrease level of coverage and/or change plan

HIPAA Special Enrollment Events. Under HIPAA, you are allowed to enroll in the Medical Plan under certain conditions including a “special enrollment” without having to wait until the next annual open enrollment period. To take advantage of a special enrollment, the following conditions must exist. You must also submit your completed request for enrollment to the Human Resources Benefits Coordinator within 30 days of the event. If you fail to complete and submit the appropriate enrollment forms within 30 days, you will need to wait until the next annual open enrollment, or when you experience a change in status, whichever occurs first.

Special Enrollment Under CHIPRA. Under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), if you or your dependent is eligible for (*but not enrolled in*) Medical coverage, you may enroll in this plan if:

- You or your dependent is covered under Medicaid or state Children’s Health Insurance Program (CHIP) and such coverage is terminated due to a loss of eligibility, provided you request coverage under the Medical Plan no later than 60 days after the Medicaid/CHIP coverage terminates; or
- You or your dependent becomes eligible for Medicaid or state CHIP, provided you request coverage under the Medical Plan no later than 60 days after you or your dependent is determined to be eligible for premium assistance.

If you are eligible, you or your dependent can request a special enrollment in the Medical Plan when:

- You have a newly acquired dependent as a result of marriage, civil union, birth, adoption (or placement for adoption); or
- There is a voluntary loss of other health coverage of any kind (including COBRA); loss of coverage does not include failure to pay premiums on a timely basis, termination of coverage for cause (making a fraudulent claim, for example), or you or your dependent’s voluntarily dropping coverage.

Conditions required to qualify for special enrollment.

- You are covered under another group health plan or other health insurance (including COBRA coverage) when the Plan was offered to you upon your initial eligibility period or during a subsequent open enrollment period; and
- You indicated during the enrollment process that you declined Medical Plan coverage because you already had other Medical Plan coverage.

If you meet both of these conditions, you will qualify for a special enrollment period if:

- Your other group health plan or other health insurance was terminated because you or your eligible dependents are no longer eligible for such coverage for any of the following reasons:
 - The HMO (or other similar plan you or your eligible dependents are enrolled in) ceases to provide coverage to individuals who no longer reside or work in a service area and no other coverage option is available to you;
 - You or your eligible dependents' employment terminates;
 - You or your eligible dependents have a reduction in hours worked;
 - Your spouse (civil union partner) dies;
 - You and your spouse divorce or legally separate;
 - You dissolve a civil union partnership;
 - Your dependent loses his/or her eligibility status;
 - The City of Manchester (or your dependent's employer) stops contributing toward coverage;
 - The other plan terminates.
- The other coverage was COBRA continuation and you or your dependent reaches the maximum length of time for COBRA continuation.

See **“Changing Your Elections During the Year”** for additional information, including how to request a special enrollment and the effective date of a special enrollment.

Paying For Your Medical Coverage

You and the City of Manchester share the cost of any Medical coverage you elect for yourself and/or your dependents. If you elect to do so, your costs for any Medical coverage may be taken out of your paycheck on a **pre-tax basis**.

Note: When contributions are deducted from your paycheck on a **pre-tax basis**, the City does not withhold any federal income or Social Security taxes. This means you may pay less into Social Security and that your Social Security benefit could be slightly lower.

Important Note About Taxation of Civil Union Benefits

If your covered civil union partner is not a dependent as currently defined by the Internal Revenue Code, contributions for his or her coverage must be paid **after-tax**. The fair market value of the City of Manchester's provided portion of the coverage is also taxable income to you for Federal tax purposes and may also be subject to State and City income tax. Administratively, the City of Manchester will deduct the entire premium on a **pre-tax** basis and then weekly will add that portion that must be made with **after-tax** dollars back into your income for federal and state tax purposes. In addition, this imputed income is subject to employer withholding of income tax amounts and tax amounts under the Federal Insurance Contributions Act (FICA). Contact Human Resources for more information.

When Coverage Begins

As an eligible employee, you must be actively at work for one full day in order for coverage (or any increase in coverage) to begin. You are considered actively at work if you are performing your regular duties.

Medical coverage begins the first of the month following your date of hire, provided you submit your elections on a timely basis.

Dependents. Coverage for your enrolled eligible dependents normally begins at the same time your coverage begins. Dependents you acquire after you are first eligible may be enrolled for coverage as explained in "**Changing Your Elections During the Year**" on page 3. You have 30 days to enroll a newly-eligible dependent.

If you are rehired or reclassified into an eligible class for benefits. If you leave the City of Manchester and are subsequently rehired or reclassified into an eligible class for benefits, you will be eligible for coverage as of the first of the month following your rehire date (or date of reclassification). You must complete the enrollment process in order to have coverage in place. Any prior coverage you may have elected will **not** be automatically reinstated.

Pre-existing conditions. There are no pre-existing condition limitations on your Medical coverage.

What Happens During a Leave of Absence

If you are on an approved paid leave of absence, you may be able to continue your coverage for up to the duration of the approved leave. In order to qualify for this continued coverage, the leave must be authorized in writing, and you must continue to pay any applicable contribution or premium that you were paying before you began your leave. Failure to continue paying the applicable contribution will result in termination of coverage. If you are on an unpaid leave of absence, leave must be authorized in writing and you must pay the full premium (other than FMLA and Workers Compensation), in most instances. Contact Human Resources for questions regarding unpaid leave.

Family Medical Leave Act of 1993 (FMLA) and Other Protected Leaves. Under the FMLA, you may be entitled to take up to a 12-week unpaid leave of absence from your job during a 12 month period if you need to care for a seriously ill family member, newborn baby, an adopted and/or foster child, or for your own serious illness, and be restored to the same or equivalent position upon your return from leave, provided you have worked for at least:

- 12 months; and
- 1,250 hours in the 12 months prior to your requested leave.

Effective January 16, 2009, you may also be entitled to up to 12 weeks of unpaid leave because of any “Qualifying Exigency” (as defined in Department of Labor Regulations) relating to your spouse’s, son’s, daughter’s and/or parent’s notification of an impending call to active duty status in support of a contingency operation in the armed services (including the Reserves or National Guard). You may also be entitled to up to 26 weeks during a 12-month period to take care of your spouse, child, parent, or next-of-kin who is undergoing medical treatment and/or recuperating from serious illness or injuries as a result of their service in the armed services.

While you are on FMLA or other qualified leave, you are entitled to continue or suspend group health coverage (Medical) for you and your eligible dependents. If you continue your participation, you must continue to pay your portion, if any, of the monthly cost of coverage or your benefits will be canceled. If you suspend your participation, benefit expenses incurred while you are on leave will not be covered under the Plan. You will have the right to be reinstated in group health coverage upon returning from FMLA or other qualified leave. Contact Human Resources for more information regarding your entitlement to this leave.

If you elect to continue your group health coverage and do not to return to work at the end of the leave, you may be required to reimburse the City of Manchester for its portion of the cost paid towards maintaining your coverage during your leave. Exceptions may be considered if you cannot return to work because of a serious health condition or other circumstances beyond your control.

At the conclusion of your FMLA leave, you may be eligible for benefits under COBRA if:

- You or your enrolled dependents are covered on the day before the first day of FMLA leave or become covered during the FMLA leave under a group health plan;
- You do not return to work at the end of the FMLA leave; and
- Your or your enrolled dependent(s) would (in the absence of COBRA) lose coverage under the group health plan before the end of what would be the maximum coverage period (for example, you would no longer be covered under the same terms and conditions as those in effect for similarly situated active employee and their enrolled dependent(s))

Note: You will not be eligible for COBRA if the City eliminates group health plan coverage for active employees during your FMLA leave. See “**Applying for Continued Health Care Coverage Under COBRA**” for more details.

In certain circumstances, your leave of absence may exceed the amount of time for which you have protection under the FMLA. If this occurs, you are eligible to continue your participation in the Medical Plan provided you are covered by paid leave (sick or vacation) and continue to pay the employee contribution towards the cost of health care. You may be eligible to continue your participation in the medical plan if you are on unpaid status subsequent to the exhaustion of FMLA leave provided you pay the full contribution (employee and employer share). Assuming you are released to return to work within a prescribed period of time (and not administratively terminated), you have the right to be reinstated to the group health plan coverage, if you previously terminated coverage during the leave.

Military Leaves of Absence

Short Term Military Leave. If you enter the armed services (including the Reserves or National Guard), you may be entitled to continue your eligible dependents’ coverage under the Plan during your military service during the entire period of activation. If you are absent from work due to military service for a period of 31 days or less (a “short term” military leave), your Medical Plan coverage will continue during your short term military leave.

Contributions for any Medical Plan coverage that remains in effect will be the same as those for any similarly situated active participants in the plan. When you return to work, you must pay your portion, if any, of the premium for any coverage that continued during your short term military leave.

If your short term military leave occurs at the same time as a change in plan year (i.e., July 1st), you may be required to make new elections effective for the new plan year. Additionally, if you experience a qualified change in status or a HIPAA special enrollment event while on a short term military leave, you may make benefit election changes consistent with the change in status upon your return.

Long Term Military Leave. If you are absent from work due to military service for a period in excess of 31 days (a “long term” military leave), you may continue Medical Plan coverage for your dependents *beginning on the 32nd day* of activation (or, if earlier, until the day after the date you’re required to apply for or return to active employment with your worksite employer). The contributions for continued Medical Plan coverage for your dependents will be paid for by the City during the entire period of activation.

Whether or not you continue coverage during military service, you may reinstate the Medical Plan coverage effective as of the date you return to active employment under the provisions of the Uniformed Services Employment and Re-employment Rights Act (USERRA). No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury connected with your military service. Separation from uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, absent without leave, or ending in a conviction under court martial, would disqualify you from any rights under USERRA.

When Coverage Ends

Your (and your eligible dependents) participation in Medical Plan coverage ends on the earliest of any of the following events:

- The last day of the month that you (or they) are no longer considered an eligible employee (or dependent) as described on page 1;
- The last day of the month you are actively at work (except as provided under the approved leave of absence provisions described on page 9);
- The date you stop making any required contributions toward the cost of your and/or your eligible dependents' coverage;
- The date the City of Manchester no longer covers your class of employees or eligible dependents; or
- The date the City of Manchester stops offering the Plan.

Medical Plan coverage continues to the end of the month in which you or dependents' eligibility ends (as applicable), or longer as described below.

Extended coverage. You may continue coverage beyond the time it would otherwise normally end by electing COBRA, as explained below.

Applying for Continued Health Care Coverage Under COBRA

What is COBRA Continuation Coverage? You (and in some cases, your eligible dependents) may have the right to continue participation in health care coverage when you would otherwise lose such coverage, under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You can extend coverage up to 18 months or in some cases up to 36 months as described below. If you qualify, you can continue your Medical Plan coverage if you were previously enrolled.

In order to qualify for COBRA continuation coverage you must have a "qualifying event" that would otherwise end your coverage. Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Only qualified beneficiaries may elect to continue their group health plan coverage. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. (Certain newborns, newly-adopted children and alternate recipients under Uniform Support Orders (USOs) may also be qualified beneficiaries.)

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including annual open enrollment and special enrollment rights. Specific information describing the coverage to be continued under the Plan is contained elsewhere in this notice. For more information about your rights and obligations under the Plan, you can get a copy of additional information from the COBRA or Plan Administrator.

When is COBRA Coverage Available? The Plan offers COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, or death of the employee, the City will notify the COBRA Administrator of the qualifying event.

Qualifying Events Applicable to Active Employees. If you are an employee, you will become a qualified beneficiary if you will lose your Medical Plan coverage because 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.

Qualifying Events Applicable to Spouses (Civil Union Partners). If you are the spouse (civil union partner) of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse (civil union partner) dies;
- Your spouse's (civil union partner's) hours of employment are reduced;
- Your spouse's (civil union partner's) employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse. (**Note:** *These same rules apply to the termination of a civil union*).

Qualifying Events Applicable to Dependent Children. Your dependent children will become qualified beneficiaries if they will 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 parents become divorced or legally separated or their civil union terminates, or;
- The child stops being eligible for coverage under the plans as a "dependent child."

Children who are born to or placed for adoption with a covered employee during the period of the employee's continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

The COBRA Administrator. Combined Services, LLC is the Plan's COBRA Administrator. For any purposes of notification, you may contact them at:

Combined Services, LLC
2 Delta Drive, Suite 301
Concord, NH 03302

Phone: 1-888-227-9745

Fax: 1-603-224-4256

You Must Give Notice of Some Qualifying Events. For certain qualifying events (i.e., divorce or legal separation of you and your spouse, or a dependent child losing eligibility for coverage as a dependent child), you (or your family member) must notify the Plan Administrator within 30 days after the later of the date the qualifying event occurs or the date of the loss of coverage due to the qualifying event. The notice must be in writing and must be sent to Human Resources. The notice must include the name of the employee, the name(s) of the qualified dependent(s), the type of qualifying event (for example, divorce), and the date of the qualifying event. If the qualifying event is divorce or legal separation, you must submit a copy of the "Notice of Decision" or written proof of the legal separation. (**Note: These same rules apply to the termination of a civil union**).

The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

How to Elect COBRA Continuation Coverage. After the COBRA Administrator has received notice of the qualifying event from the Plan Administrator, the COBRA Administrator will send a COBRA notification to each qualified beneficiary. 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 (civil union partners), and parents may elect COBRA continuation coverage on behalf of their children.

Qualified beneficiaries have 60 days from the later of the date:

- Of the loss of coverage because of the qualifying event, or;
- They receive a COBRA Election Notice, to elect COBRA continuation coverage.

Election forms must be post-marked within that 60-day period and must be received by the COBRA Administrator.

For each qualified beneficiary who timely elects and pays for COBRA continuation coverage, coverage will begin on the date that coverage under the Plan would otherwise have been lost due to the qualifying event. If you timely elect (and pay for) COBRA continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If you do not timely elect (and pay for) COBRA continuation coverage, your health coverage under the Plan will end.

IF YOU OR YOUR DEPENDENTS DO NOT PROVIDE A NOTICE OF A QUALIFYING EVENT TO THE PLAN ADMINISTRATOR BY THE END OF THE 60-DAY PERIOD, THE AFFECTED SPOUSE (CIVIL UNION PARTNER) OR DEPENDENT WILL NOT BE ENTITLED TO CHOOSE COBRA CONTINUATION COVERAGE.

Special Note. In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. First, if you have more than a 63 day gap in health coverage, you risk having pre-existing condition exclusions applied to you by other group health plans. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost of COBRA Coverage. As provided by law, you and/or your covered dependents must pay the full premium cost of coverage plus 2% for administrative expenses for the full 18- or 36- month period. In cases of extended continuation coverage due to disability, the cost for months 19 to 29 is 150% of the full premium cost for the coverage. The COBRA Administrator will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and will also notify you of any changes in the monthly COBRA premium amount.

Paying for COBRA Continuation Coverage. You must send the initial payment for COBRA coverage to the COBRA Administrator within 45 days of the date you choose COBRA coverage (a U.S. Post Office postmark will serve as proof of the date you sent your payment). You must submit payment to cover the number of months from the date of regular coverage termination to the time of payment (or to the time you wish to have COBRA coverage end). If you do not make this payment within 45 days of the date of your COBRA election, you (and your family members) will not be entitled to COBRA continuation coverage.

After the initial premium payment, monthly premium payments are due on the first day of each month, and there will be a grace period of 30 days each month to make these payments. If you fail to pay by the end of the grace period, your (and your family's) coverage will cease as of the last day of the last fully paid period. Once coverage ends, it cannot be reinstated. To avoid cancellation, your payment must be sent and postmarked by the U.S. Post Office on or before the last day of the grace period and must be received by the COBRA Administrator. A check that has been returned unpaid from the bank for any reason may result in untimely payment and can result in cancellation of coverage.

How Long Does COBRA Continuation Coverage Last? COBRA continuation coverage is a temporary continuation of coverage. The following chart shows the qualifying events and the periods of eligibility for COBRA continuation coverage.

Qualifying COBRA Events		
If You Lose Coverage Because:	These People Would Be Eligible:	For COBRA Coverage For Up To:
Your employment terminates	You and your eligible dependents	18 months
Your working hours are reduced	You and your eligible dependents	18 months
You are determined to be disabled by the Social Security Administration	You and your eligible dependents	29 months
You die	Your dependents	36 months
Your marriage is civilly annulled	Your dependents	36 months
You divorce or legally separate (or terminate a civil union)	Your dependents	36 months
Your dependent children no longer qualify as dependents	Your dependent children	36 months
You are retired and you become entitled to Medicare benefits	Your dependents	36 months

If the qualifying event is the end of your employment or reduction in your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse (DP) and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension of 18-month COBRA coverage period for Social Security Disability. If you or any enrolled dependent is determined by the Social Security Administration (SSA) to be disabled for Social Security disability purposes at some time before the 60th day of COBRA continuation coverage, you may continue coverage for an additional 11 months, up to a maximum of 29 months, from your original qualifying event date. The cost of this extended coverage will be increased to 150% of the full premium cost. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension.

You must inform the COBRA Administrator of your disability in writing within 60 days of the later of:

- The date of the Social Security Administration's disability determination letter;
- The date on which your qualifying event occurred, or;
- The date on which the qualifying beneficiary lost coverage as a result of the qualifying event.

In addition, you must notify the COBRA Administrator in writing before the end of your 18-month period of continuation. Be sure to enclose a copy of the Social Security disability determination letter. If you do not notify the COBRA Administrator within the timeframes stated above, you will not qualify for this extension.

Extension of 18-month COBRA coverage period due to a second qualifying event. If your spouse (civil union partner) or dependents have another qualifying event while receiving COBRA continuation coverage because of your termination of employment or reduction in hours, your spouse (civil union partner) and dependent children may elect additional COBRA coverage, up to a maximum of 36 months, if proper notice is provided to the COBRA Administrator. This extension is available to your spouse (civil union partner) and dependent children if you die, or get divorced or legally separated (or terminate a domestic partnership) or become entitled to Medicare (Part A, Part B or both). The extension is also available to a dependent child when he or she stops being eligible under the plan as a dependent child. In all of these cases, you must notify the COBRA Administrator of the second qualifying event within 60 days after the second qualifying event. If you do not notify the COBRA Administrator in writing within the 60-day period, you will not qualify for this extension.

Acquiring New Dependents While Covered By COBRA. Children who are born to or placed for adoption with a former covered employee during the period of the employee's continuation coverage are qualified beneficiaries and are entitled to COBRA continuation coverage for the same maximum period as the other qualified beneficiaries with respect to the same qualifying event. You may also add a new spouse (civil union partner) to your coverage while you are on COBRA continuation coverage, but the new spouse (DP) is not thereby a qualified beneficiary. In order to add a newly acquired dependent, you must notify the COBRA Administrator within 30 days of the marriage (or establishing a domestic partnership), birth or placement for adoption and pay the required premium within 45 days of returning your election form. You must include payment for all months retroactive to the date you acquired the dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 month COBRA coverage period, COBRA coverage also will end for your newly added spouse (civil union partner). However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the COBRA Administrator for more details on how long COBRA coverage can last.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage. If, while you are enrolled in COBRA Continuation Coverage, your spouse (civil union partner) or dependent loses coverage under another group health plan, you may enroll the spouse (civil union partner) or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse (civil union partner) or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the plan and declined, the spouse (civil union partner) or dependent must have been covered under another group health plan or had other health insurance coverage.

You should enroll the spouse (civil union partner) or dependent within 30 days after the termination of the other coverage. Adding a spouse (civil union partner) or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Losing COBRA Coverage. COBRA coverage will end sooner than shown on the chart (page 15) on the occurrence of any of the following events:

- The date, after the date of the COBRA election, on which you or your eligible dependent become entitled to coverage under Medicare (Part A, part B, or both) or another group health care plan (unless the new plan will not cover a pre-existing condition for which you or a dependent are being treated);
- The first day of the time period for which you do not pay the COBRA premiums on time;
- The date on which the City stops providing these benefits to employees;
- Coverage has been extended for up to 29 months due to disability and there has been a final Social Security Administration determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination; you are required to notify the COBRA Administrator in writing within 30 days of any such final determination;
- Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving the continuation coverage (such as fraud).

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 also should keep a copy of any notices you send to the Plan Administrator.

For More Information

It's important to keep in mind that this section provides a general description of the eligibility and participation provisions that apply to the Plan. If you have any questions regarding your own situation, you are encouraged to call the Human Resources Benefits Coordinator at **1-603-624-6543**.

Administrative Information

No Continued Right to Employment

Being a participant in any of the benefit options under the Plan does not give you any right of continued employment with the City of Manchester.

HIPAA Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directed the U.S. Department of Health and Human Services to issue various rules known as the HIPAA regulations. These rules addressed a few topics including:

- ***Health care portability features that placed limits on the preexisting condition exclusions from health care coverage.*** This means that when you, your spouse or dependents lose coverage under the health plan, the covered individuals will be entitled to a certificate which provides evidence of prior health coverage. You may need to furnish this certificate to another employer if you become eligible under a group health plan that excludes coverage for certain medical conditions that you had before you enroll. Under the law, a pre-existing condition exclusion may not be imposed for more than 12 months (18 months for a late enrollee). This 12-month (or 18-month) period is reduced by any prior health coverage. HIPAA requires that prior health coverage count towards satisfying the pre-existing limit. In short, this makes your prior health coverage “portable” because it is credited toward any pre-existing condition exclusion.

Prior health coverage will count toward the pre-existing condition limitation as long as you have not had a break in coverage between the old plan and the new plan of 63 or more days. Upon request to the Plan Administrator, you have the right to receive a certificate of prior health coverage. If you lose coverage under the Plan, check with the plan administrator of any new plan under which you become covered to see if your new plan excludes pre-existing conditions and if you need to provide a certificate of previous coverage.

- ***Nondiscrimination rules for health plans (affecting premiums, contributions, wellness programs, “at-work” coverage requirements, etc.).***
- ***Confidentiality and privacy and certain individual rights in connection with the handling of your health information by health plans.*** HIPAA generally requires that group health plans provide covered employees with a privacy notice that describes in detail all of the permitted uses and disclosures of health information by the health plan and explains privacy rights under HIPAA. Please refer to the addendum at the end of this booklet for these details.

Genetic Information Non-discrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination in health coverage and employment based on genetic information. GINA, together with provisions of the Health Insurance Portability and Accountability Act (HIPAA), generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual's family members, or using this information for decisions regarding coverage, rates, or preexisting conditions. GINA also prohibits employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

How Benefits Can Be Forfeited or Delayed

While the Claims Administrator is committed to paying claims promptly, you may forfeit or delay reimbursement of eligible expenses or claims if:

- You or your beneficiary do not properly file a claim within the time period required;
- You do not furnish information or supporting documentation required to complete or verify your claim;
or
- Your current address is not on file with the City or the Claims Administrator.

You should also be aware that reimbursements are not payable for dependents who become ineligible due to age or change in marital status. Finally, you should know that benefits may be lost if they were described or paid to you in error, or were not authorized by the Claims Administrator.

Compliance With Federal Law

The Medical Plan is governed by guidance issued by the Internal Revenue Service and the Department of Labor, and current tax and federal law. The Medical Plan will always be construed to comply with the guidelines and laws currently in effect.

Applicable state law. Generally, federal law pre-empts (that is, takes precedence over) state law. However, in any situation where state law is not pre-empted and the applicable state law is not specified in the Plan document, then the statutory and common law of the State of New Hampshire will apply, including its statute of limitations and other substantive and procedural law, but not including its choice of law provisions.

Ownership of Benefits

The benefits described here are exclusively for eligible City of Manchester employees or their properly designated beneficiaries and, if applicable, their enrolled dependents. It is a condition of the Plan, and all rights of each Participant and beneficiary shall be subject thereto, that no right or interest of any Participant or beneficiary in the Plan and no benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any action by way of anticipating, alienating, selling, transferring, assigning, pledging, encumbering, or charging, the same shall be void and of no effect; nor shall any such right, interest or benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of the person entitled to such right, interest or benefit, except as specifically provided in this Plan or in the applicable insurance contract.

Subrogation and Third-Party Reimbursement

These provisions apply when the Claims Administrator pays benefits as a result of any injury, illness, impairment or medical condition you sustain and you have a right to (or have received) a recovery. For the purposes of this section, “recovery” means money you receive from another party, the other party’s insurer, or from any homeowner’s, uninsured motorist, underinsured motorist, medical payments, no-fault, personal injury protection, or other insurance coverage provision as a result of injury, illness, impairment or medical condition caused by another party or by you. Regardless of how you (or your representative or any agreements) characterize the recovery you receive, it will be subject to the “Subrogation and Third-Party Reimbursement” provisions described below.

Subrogation. If you suffer an injury, illness, impairment or medical condition that is the result of another party’s actions, and you receive benefit payments from the Claims Administrator, the Claims Administrator will be subrogated to your recovery rights and may proceed in your name against the responsible party. Additionally, the Claims Administrator has the right to recover payments made on your behalf from any party responsible for compensating you for your injury, illness, impairment or medical condition. All of the following will apply, except to the extent limited by applicable law:

- The Claims Administrator may pursue its subrogation rights for the full amount of benefits it has paid from any recovery regardless of whether you have been fully compensated, or the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to allow the Claims Administrator to exercise these rights (and do nothing to prejudice such rights).
- The Claims Administrator has the right to take whatever legal action it sees fit against any party (or entity) to recover benefits paid under this Plan.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Claims Administrator’s subrogation claim and any claim still held by you, the Claims Administrator’s subrogation claim will be satisfied before any part of a recovery is applied to your claim, your attorney fees, or other expenses or costs.
- The Claims Administrator is not responsible for any attorney fees, other expenses or costs you incur without the prior written consent of the Claims Administrator.

Reimbursement. If you recover expenses from a third party and the Claims Administrator has not been repaid for benefits the Claims Administrator paid on your behalf, the Claims Administrator has a right to be repaid from the recovery up to the amount of the benefits paid on your behalf. All of the following will apply, except to the extent limited by applicable law:

- The Claims Administrator is entitled to full reimbursement from any recovery, notwithstanding any allocation made in a settlement agreement or court order, and even if the recovery does not fully satisfy a judgment, settlement or underlying claim for damages or fully compensate or make you whole.
- You and your legal representative must hold in trust for the Claims Administrator the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid immediately upon your receipt of the recovery. You must fully reimburse the Claims Administrator, without any set-off or reduction for attorney fees, or other expenses or costs.

- The Claims Administrator will be entitled to deduct any of the unsatisfied portion of the amount of benefits it has paid or the amount of your recovery, whichever is less, from any future benefits payable by the Claims Administrator if:
 - You fail to disclose the amount of your recovery,
 - The amount the Claims Administrator paid on your behalf is not repaid or otherwise recovered by, and/or
 - You fail to cooperate with the Claims Administrator.
- The Claims Administrator will also be entitled to recover any of the unsatisfied portion of the amount paid it has paid or the amount of your recovery, whichever is less, directly from the providers to whom payments have been made. In such a circumstance, it may then be your obligation to pay the provider the full amount billed, and the Claims Administrator will have no obligation to pay the provider.

Divorce and Your Plan Benefits

New Hampshire state law requires group health plans to honor USOs. In general, USOs are state court orders requiring a parent to provide medical support to a child – for example, in cases of legal separation or divorce.

A USO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child does not reside with you and is not claimed as your dependent on your federal tax return. In order to qualify as a USO, the medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- Specifies your last known name and address, and the child's name and last known address;
- Provides a reasonable description of the type of coverage to be provided by the Plan, or the manner in which the type of coverage is to be determined;
- States the period to which it applies; and
- Specifies each plan to which it applies.

The USO may not require the Plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan.

Plan Administration

The Claims Administrator and the Plan Administrator all play a role in supervising the Plan.

- **Human Resources** is responsible for routine administration, such as answering questions concerning eligibility, coverage and administration, and providing basic information about the plans.
- **The Claims Administrator** has sole and absolute discretionary authority to determine whether you have incurred a covered expense for which benefits may be payable under the Plan and to determine the amount, and administer the payment, of any such benefits under the Plan. (See “**Plan Facts**” beginning on page 24 for identification of the Claims Administrator.)
- **The Plan Administrator** (City of Manchester) (or its designee) shall have the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator (or its designee), shall have the sole and absolute discretionary authority:
 - To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
 - To formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
 - To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
 - To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and
 - Except as provided to the contrary under the Plan, the governing documents and applicable law, to process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or its designee) with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties. If any such determination shall involve a question of law, the Plan Administrator (or its designee) may rely and act upon the advice of counsel with respect thereto.

All claims should be directed to the applicable administrator (either the Claims Administrator or the Plan Administrator) and the entire claims procedure and appeals process, as described in each portion of this Plan, will be handled through that administrator. Please refer to your Subscriber Certificate for more information on filing a claim for benefits.

You will find that most of your questions regarding the Plan can be answered by the Claims Administrator or the Human Resources Department.

If conflicts arise. The City of Manchester and the Claims Administrator will always try to give you the most complete and accurate information regarding the Plan. Should there be a discrepancy between what is conveyed to you and the terms of the Plan document, federal law requires that the Plan documents always control. Depending on the nature of your issue, the Plan Administrator or the Claims Administrator, using the Plan documents, will make the final determination.

Additional administrative information. The Plan Administrator may delegate its responsibilities among employees of the City of Manchester, and may consult with or hire outside experts. The Committee is designated by the Board of Mayor and Aldermen of the City of Manchester (the “Board”). Further, the Human Resources Director has authority to execute governmental filings or other documents relating to the Plan. This authority may also be delegated to employees of the City of Manchester by the Board of Mayor and Aldermen.

Any discretionary actions to be taken under the Plan by the City with respect to the classification of the Participants, contributions, or benefits shall be uniform in their nature and applicable to all Participants similarly situated. With respect to service with the City of Manchester, leaves of absence and other similar matters, the City of Manchester shall administer the Plan in accordance with the regular personnel policies in effect at the time.

Future of the Plans

The City of Manchester has every intention of continuing the Plan indefinitely, but reserves the right to change, terminate, suspend, withdraw, reduce, amend or modify the Plan at any time, in any manner, at the City of Manchester’s sole discretion, according to the procedures set out in the official plan documents. Any change or termination of benefits will be based solely on the decisions of the City of Manchester and may apply to active employees, dependents of employees, retirees under age 65, and participants covered through COBRA, as either separate groups or as one group. You will be notified of any change (*the change may be effective, however, before any notice is delivered to you*).

Plan amendments. Plan amendments will be made by action of the Plan Administrator (or its designee). In addition, premium and contribution rates may change from year to year, as determined by the Plan Administrator.

Plan Facts

Plan Name:	City of Manchester Health and Welfare Plan
Plan Number:	358279
Plan Sponsor:	City of Manchester One City Hall Plaza Manchester, NH 03101 1-603-624-6543
Employer Identification Number:	026000517
Plan Administrator:	City of Manchester One City Hall Plaza Manchester, NH 03101 1-603-624-6543
Agent for Service of Legal Process:	Process may be served upon the Plan Administrator at the address indicated above.
Plan Year:	July 1 – June 30
Type of Plan:	Welfare Plan; The Plan also includes a cafeteria plan under Code Section 125; The cafeteria plan is not subject to ERISA.
Claims Administrator:	Anthem Blue Cross and Blue Shield 3000 Goffs Falls Road Manchester, NH 03111
Type of Administration:	Self-insured; administrative services contract
Type of Funding:	City of Manchester and employee contributions

HIPAA Privacy & Security Rule Addendum

Permissible Uses and Disclosures

The Plan Sponsor shall only use or disclose Protected Health Information (“PHI”) of participants to the extent it is permitted under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Your PHI will not be used or disclosed without your written authorization, except as described in the City of Manchester Privacy Notice (the “Privacy Notice”) or as otherwise permitted by federal and state health information privacy laws. The Privacy Notice is available by contacting the Human Resources Director at **1-603-624-6543** and is also available online at www.manchesternh.gov/cityview. It describes what the Plan is required by law to do and how the Plan will comply, and provides an explanation of your rights regarding your own health information. If you have any questions or concerns, please contact the Human Resources Director at **1-603-624-6543**.

Any term not specifically defined herein shall have the same meaning as set forth in 45 C.F.R. Parts 160 and 164, where applicable.

The Plan will disclose PHI to the City of Manchester only upon receipt of a certification by the City of Manchester that it agrees to keep your PHI confidential. In addition, the City of Manchester must agree to handle your PHI in a way that enables the Plan to comply with HIPAA. Toward that end, the City of Manchester hereby certifies that the Plan document (including this SPD) has been amended to incorporate the following provisions, and the City of Manchester agrees to the following rules in connection with your PHI that is received from, or on behalf of, the Plan:

- The City of Manchester understands that the Plan will only disclose your PHI to the City of Manchester for the City of Manchester’s use in Plan administrative functions and such disclosures explained in the Privacy Notice. In all cases, the City of Manchester will receive only the minimum necessary amount of PHI necessary for the City of Manchester to perform Plan administrative functions
- The City of Manchester will only use or disclose your PHI for reasons relating to your medical treatment, payment for your medical treatment, or healthcare operations, unless it receives your permission. The City of Manchester will not use or disclose your PHI for any reason other than as permitted in the SPD except if required by law.
- If the City of Manchester discloses to any of its agents or subcontractors any of your PHI that it receives from the Plan, the City will require the agent or subcontractor to handle your PHI and keep it private to the same extent as if your information was handled directly by the City of Manchester.
- The City of Manchester will not use or disclose your PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan sponsored by the City of Manchester, unless the City of Manchester receives your express written authorization.
- The City of Manchester will promptly report to the Plan if it becomes aware of any use or disclosure of your PHI that is inconsistent with the uses or disclosures permitted by this Plan document.

- The City of Manchester will allow you or the Plan to inspect and copy your PHI that is in the City of Manchester's custody and control to the extent permitted or required under the HIPAA regulations. (You should review the Privacy Notice to learn more about your rights to receive copies of certain types of your health information maintained by the Plan.)
- The City of Manchester will allow you to amend, or allow the Plan to amend, portions of your PHI to the extent permitted or required under the HIPAA regulations. (You should review the Privacy Notice to learn more about your rights to request an amendment to the health information that is maintained by the Plan.)
- The City of Manchester will keep a written record of certain types of disclosures that it makes, if any, of your PHI for reasons other than your medical treatment, payment for that medical treatment, or health plan operations. This written disclosure record will include those types of disclosures made for at least the previous six years, except only disclosures made after April 14, 2003 must be listed. The City will make this disclosure record available to the Plan so that the Plan can provide you, upon request, with a copy of that list of disclosures. (You should review the Privacy Notice to learn more about your rights to request a log of certain types of disclosures of your health information that are made by the Plan.)
- The City of Manchester will make its internal practices, books, and records relating to its use and disclosure of your PHI received from the Plan available to Department of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA regulations.
- The City of Manchester will, if feasible, destroy or return to the Plan all of your PHI in the City of Manchester's custody or control that the City of Manchester has received from the Plan and retain no copies, when the City of Manchester no longer needs your PHI to administer the Plan. If it is not feasible for the City of Manchester to return or destroy your PHI, the City of Manchester will limit the further use or disclosure of any of your PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information not feasible.
- Only those City of Manchester employees who perform plan administrative functions for the Plan shall have access to or be able to use PHI. Only the following classes of employees may be given or afforded such access or use: Benefits Administration only.

The access or use of PHI by these employees is restricted to Plan functions that these employees perform for the Plan. If any of these employees or workforce use or disclose your PHI in violation of the rules that are set out in this SPD, those employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the City of Manchester becomes aware of any such violations, the City of Manchester will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

Electronic Health Information

There are also some special rules under HIPAA related to “electronic health information.” Electronic health information is generally PHI that is transmitted by, or maintained in, electronic media. “Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, the City of Manchester will take additional action with respect to the implementation of security measures (as defined in 45 C.F.R. § 164.304) for electronic PHI. Specifically, the City of Manchester will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation required to exist between the Plan and the City of Manchester is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect that information;
- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and
- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic PHI by the issuance of additional regulations or other guidance pursuant to HIPAA.