



CITY OF WORCESTER

HUMAN RESOURCES DEPARTMENT

455 Main Street, Room 109
Worcester, Massachusetts 01608
Phone: (508) 799-1030 Fax: (508) 799-1040

DORI A. VECCHIO
Director

Welcome New Employee!

As part of your employment with the City of Worcester, you are entitled to specific benefits explained further in this packet. Benefits include medical insurance, dental insurance, vision insurance and life insurance. In addition to other information included here, you should know that:

- ◆ You are entitled to benefits as of your first day of work; **however once you have completed the necessary paperwork please allow at least two weeks for processing.**
- ◆ You must enroll (completed paperwork delivered to Room 109 – City Hall) no later than thirty (30) days following your first day of work. **Incomplete paperwork will not be accepted.**
- ◆ Medical, dental, and vision insurance is paid one month in advance; so initial premiums are doubled until you get 'caught up'.
- ◆ If you choose not to enroll during your first 30 days of employment with the City, you cannot enroll until the annual open enrollment, unless you have a **'qualifying event'** (ex: loss of coverage, marriage, divorce, birth, etc.)
- ◆ To enroll a dependent in the medical, dental or vision plan, **you must provide the following documentation:**

<u>Relationship</u>	<u>Documentation</u>
Spouse	Copy of certified marriage certificate (not church record)
Divorced or Separated Spouse	Copy of the health insurance provision language from divorce/separation agreement, and signature page.
Children (dependents) to age 26 covered for medical, dental and vision.	Copy of certified birth certificate, or Court Order documenting guardianship, or adoption papers.

- ◆ Without the above required information, the dependent will not be enrolled in your plan. You will also need to know your dependent's social security number, and primary care physician.
- ◆ **Qualifying events**, which allow you to make changes to your coverage, include: marriage, death, divorce, adoption, birth of a child, spouse's loss of coverage, etc.
- ◆ If you are on a Leave of Absence, please notify this office for information on how this affects your benefits.
- ◆ Unless you choose otherwise, benefit premiums are deducted from your paycheck on a pre-tax basis.
- ◆ **The Benefits Office is located in Room 109 of City Hall, 455 Main St., and can be reached by calling (508) 799-1030. Office hours are Monday – Friday from 8:30-5:00.**
- ◆ You should always call the Benefits Office for any questions regarding your benefits.

If you visit the City's website at <http://www.worcesterma.gov/human-resources/benefits> you can download information and forms for most of your benefits.

YOUR BENEFITS INCLUDE:

BENEFIT	SUMMARY	REQUIREMENTS										
Medical Insurance	The City offers four plan choices: BCBS Blue Care Elect Preferred (enrollment restricted to those employees residing outside of New England (or their dependents residing outside of New England), BCBS Network Blue New England, and the City of Worcester Advantage plans – Advantage & Direct and City Advantage Qualified High Deductible Plan with HSA	All new employees must enroll within their first 30 days of employment. If paperwork is not completed at this time, you may not be able to enroll until the annual open enrollment period (held annually in the spring with a July 1 effective date). If enrolling dependents you will be required to provide a marriage certificate and/or birth certificate upon enrollment. Your insurance begins as of your date of hire, and premiums are paid one (1) month in advance.										
Dental Insurance	The City offers a dental benefit through Altus Dental. You have three options to choose from: Low Option, High Option, and High Plus (orthodontia is available with High plans ONLY).	Same requirements as above, however, since the dental plan is 100% employee-paid, cancellation is restricted to the annual open enrollment except for specific 'qualifying events'										
Vision Insurance	Through United HealthCare you can choose from Employee only, Employee + One or Employee + Family.	Same requirements as above, however, since the dental plan is 100% employee-paid, cancellation is restricted to the annual open enrollment except for specific 'qualifying events'										
Term Life Insurance	<p>Plan A: a basic, \$5000 policy, available for \$6.48 per month.</p> <p>Plan B: (only available if you have Plan A. Cannot have Plan B without Plan A) optional coverage available in \$10,000 increments up to 3 times your annual salary or max of \$505,000</p> <p>Plan B premiums – rate is based on age, cost is per \$1,000 of coverage.</p> <table border="1" data-bbox="483 1255 885 1434" style="margin-left: auto; margin-right: auto;"> <tr> <td><30: .122</td> <td>50-54: .472</td> </tr> <tr> <td>30-34: .137</td> <td>55-59: .832</td> </tr> <tr> <td>35-39: .161</td> <td>60-64: .976</td> </tr> <tr> <td>40-44: .221</td> <td>65-69: 1.725</td> </tr> <tr> <td>45-49: .310</td> <td>70-99: 2.857</td> </tr> </table>	<30: .122	50-54: .472	30-34: .137	55-59: .832	35-39: .161	60-64: .976	40-44: .221	65-69: 1.725	45-49: .310	70-99: 2.857	<p>Through Unum Life Insurance Company, enrollment is limited to new hires and at the annual open enrollment period.</p> <p>For new hires, Evidence of insurability is required for any amount over \$205,000.</p> <p>For enrollment at open enrollment, Evidence of insurability is required of any amount.</p> <p>Spouse and children coverage is also available You must be enrolled in Plan A and Plan B to elect Spouse or Child coverage.</p> <p>Optional ends at 75 unless an active employee.</p>
<30: .122	50-54: .472											
30-34: .137	55-59: .832											
35-39: .161	60-64: .976											
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<ul style="list-style-type: none"> *Universal Life Insurance *Accident Insurance *Critical Illness *Short Term Disability *Long Term Disability 	Enrollment in the Trustmark/MMIP voluntary products is held annually at the spring open enrollment period and information is available for new hires to contact a representative.	If enrolled at initial offering/ eligibility, Life and Disability plans are available on a 'modified' guarantee issue basis (a simple medical questionnaire).										
<ul style="list-style-type: none"> *Medical/Dependent Spending *Transportation/Transit/ Parking Account 	Spending account enrollments through Cafeteria Plan Advisers (CPA) require no medical documentation and you must re-enroll each year during the annual open enrollment.	Plan year is a fiscal year, July 1 – June 30 th . We have a Grace Period of 75 days, so claims through September 12. Plan conservatively because if you don't use it, you lose it.										



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Waiver of Insurance Coverage

This form must be completed in accordance with Massachusetts General Laws, Chapter 32B. It must be returned to Room 109, City Hall. Completing this form does not mean that you are waiving your rights to coverage permanently – it simply means that you do not wish specific coverage at this time. You have the right to change your information on this form during your first thirty (30) days of employment, at the annual open enrollment, or if you have a change in employment or family status which constitutes a 'qualifying event'.

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ EMAIL _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ HOME PHONE _____ CELL _____

DEPARTMENT _____ START DATE _____

Unless you choose otherwise, benefit premiums are deducted from your paycheck on a pre-tax basis.

At this time, I choose to waive the following benefits for myself and any qualified beneficiaries:
(Please, check off those benefits that you **ARE NOT** enrolling in)

_____ Medical Insurance (BCBS, City of Worcester Advantage/Direct)

_____ Altus Dental Insurance (High or Low)

_____ United Healthcare Vision Insurance

_____ Unum Basic Term Life Insurance

_____ Unum Optional Term Life Insurance

_____ Unum Spouse/Child Term Life

_____ Section 125 – Medical/Dependent Care Spending

_____ Section 132 - Transportation Plans (Parking/Mass Transit)*

*Can enroll and make changes at a later date – doesn't need to be a qualifying event.

Employee Signature

Date



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 January 31, 2018. Contact your State for more information on eligibility –

MAINE - Medicaid	RHODE ISLAND - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
MASSACHUSETTS – Medicaid & CHIP	VERMONT - Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW HAMPSHIRE – Medicaid	
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	

To see if any other states have added a premium assistance program since January 31, 2018 or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

City of Worcester Initial COBRA Notice

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or COBRA coverage) in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that employers may maintain and that provides medical care. For simplicity, any such group health plan is referred to in this Notice as the “Plan.” You do not have to show that you are insurable to elect continuation coverage; however, you will have to pay all of the premium for your continuation coverage. At the end of the maximum coverage period (described below), you will be allowed to enroll in an individual conversion health plan if it is otherwise available under the Plan, subject to the requirement to pay the premiums required by the individual conversion health plan.

This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the employee) and your spouse should read this summary carefully and keep it with your records!

Qualifying Events

If you are the **employee** of the Employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the two “qualifying events”:

1. Termination of employment (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the **spouse** of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four “qualifying events”:

1. The death of your spouse.
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the Employer. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the Employer.
3. Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the later divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of an employee covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five “qualifying events”:

1. The death of the employee-parent.
2. The termination of the employee-parent’s employment (for reasons other than gross misconduct) or reduction in the employee-parent’s hours of employment with the Employer.
3. Parent’s divorce or legal separation.
4. The employee-parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a “dependent child” under the Plan.

Your IMPORTANT Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child’s losing dependent status under the Plan, then you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child’s losing dependent status. You or your spouse or dependent *must* provide this notice no later than 60 days after the date coverage terminates under the plan. *If you or your spouse or dependent child fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered to elect continuation coverage.* Furthermore, if you or your spouse or dependent child fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses after the date coverage terminate upon the divorce, legal separation, or a child’s losing dependent status, then you, your spouse, and your dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with the notice of a divorce, legal separation, or a child's losing dependent status that caused a loss of coverage, then the Plan Administrator will notify the effected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address - See the YOU MUST NOTIFY US paragraph below).

The Plan Administrator will also notify you (the employee), your spouse and dependent children of the right to elect continuation coverage after it receives notice of the following events that results in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee's becoming entitled for Medicare.

Election Procedures

You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60-days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Plan Administrator is considered to be mailed on the date of mailing.

You (the employee) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it.

You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Employer maintains more than one group health plan (or offers a choice of separate benefit packages under a single plan), you (or your spouse or dependent children) may elect COBRA coverage under one or more of those plans (or separate benefit packages) in which you have coverage. For example, if you are covered under three separate Employer plans (*e.g.*, a medical plan, a dental plan, and a vision plan), you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

If the Employer maintains a health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (*i.e.*, year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred. If there is a negative account balance (*i.e.*, year-to date-contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the health FSA.

COBRA Premiums That You Must Pay

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent children by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until the month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you don't make the full premium payment

by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of COBRA Coverage Before the end of the Maximum Coverage Period.”

36 Months. If you (the spouse or dependent child) lose group health coverage because of the employee’s death, divorce, legal separation, or the employee’s becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 Months. If you (the employee, spouse or dependent child) lose group health coverage because of the employee’s termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage is 18 months for the date of termination or reduction in hours. There are three exceptions:

1. If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under Social Security Act must be provided to the Plan Administrator within both the 18-month coverage period and 60 days after the date of the determination.
2. If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.
3. If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and the dependent child) is three years from the date the employee became entitled to Medicare.

Shorter Maximum for Health FSAs. The maximum COBRA period for a health flexible spending arrangement health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event, as explained above) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative balance as of the date of the qualifying event, no COBRA coverage will be offered.

Children Born to or Placed for Adoption With the Covered Employee During COBRA Period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary, provided that, the covered employee has elected continuation coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA’s special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under “Children born to or Placed for Adoption With the Covered Employee During COBRA Period,” dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries and their coverage will end and at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under QMCSOs

A child of yours (the employee's) who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during your (the employee's) period of employment with the employer is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

Termination of COBRA Coverage Before the End of Maximum Coverage Period

Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than the 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us about Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If you or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA notices and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or your dependent *must* promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA right for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

Plan Administrator

The Employer is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to the Plan Administrator.

For More Information

If you, your spouse or dependent children have any questions about this notice or COBRA, please contact the Benefits Office (Plan Administrator) at (508-799-1030) if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

Employee Health Insurance Responsibility Disclosure Form

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at www.mahealthconnector.org

Employer Section

Employers: please complete this section. See instructions below.

Employer Name: CITY OF WORCESTER

FEIN: 04-6001418

Employer D/B/A:

Employer Address: 455 MAIN STREET – ROOM 109

City | State | ZIP Code: WORCESTER, MA 01608

- Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes No
- Did you offer employer sponsored health insurance to this employee? Yes No
- If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank) \$134.09

Employee Section

Employees: please complete this section. See instructions below.

Employee First Name: _____

Employee Last Name: _____

- Did you accept your employer sponsored health insurance? Yes No
- Did you agree to use your employer's "Section 125 Cafeteria Plan"? Yes No
- Do you have other health insurance? Yes No

Employee Affidavit

I hereby affirm, under penalties of perjury that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature: _____

Date (MM/DD/YY): _____

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.

Instructions

EMPLOYER INFORMATION

Employer Name

The employer must enter the company's legal name.

FEIN

The employer must enter the Federal Employer Identification Number.

D/B/A

The employer must enter the company's trade name "Doing Business As" here, if applicable.

Employer Address

The employer must enter the business address including city, state, and ZIP Code.

Questions 1

The employer must indicate either Yes or No.

Questions 2

The employer must indicate either Yes or No.

Questions 3

The employer must report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee, if the employer offers a sponsored health plan (i.e. the employer offers to pay for a portion of the premium).

EMPLOYEE INFORMATION

Employee First Name

The employee or employer must enter the employee's first name.

Employee Last Name

The employee or employer must enter the employee's last name.

Employee Social Security or Tax Identification Number

The employee or employer must enter the employee's Social Security or Tax Identification number.

Questions 1

The employee must indicate Yes, No, or None Offered if health insurance is not offered.

Questions 2

The employee must indicate Yes, No, or None Offered if a "Section 125 Cafeteria Plan" is not offered.

Questions 3

The employee must indicate either Yes or No.

Employee Signature

The employee must sign and date the Employee Health Insurance Responsibility Disclosure (HIRD) form.

Note to Employer Regarding Employee Signature

If the employee refuses to sign and date the form, the refusal should be noted in writing and signed by the authorized company representative (e.g., the owner, supervisor or manager, chief executive officer, etc.).

City of Worcester Health Plans

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

City of Worcester and its health plans ("the Health Plans") are providing this notice to you as required by the Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated thereunder.

This Privacy Notice describes how the Health Plans may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Disclosures Under the Privacy Rule

Under the HIPAA Privacy Rule we may and do use and disclose protected health information without your prior written authorization for certain purposes. For example, we use protected health information in providing your health coverage. We use that information for treatment (for example, to help your providers coordinate and manage your health care), for payment (for example, to provide payment to your health care providers for the health care they provide to you) and for health care operations (for example, to conduct quality assessment and improvement activities). All of the above disclosures are made only for the purposes described in this Notice or as permitted by law.

The Privacy Rule also permits disclosure of protected health information by a covered entity without the member's prior written authorization, and without providing the member the opportunity to agree or object, in the following situations:

- 1.) Where use or disclosure is required by law.
- 2.) To a public health authority that is authorized by law to collect or receive such information.
- 3.) To a governmental authority where there is a reasonable belief by the covered entity that the individual is a victim of abuse, neglect or domestic violence.
- 4.) To a health oversight agency for oversight activities authorized by law.
- 5.) In the course of certain judicial or administrative proceedings in response to a court order, subpoena, discovery request or other lawful process.
- 6.) To a law enforcement official for certain law enforcement purposes.
- 7.) To a coroner, medical examiner or funeral director for identification of a decedent and similar purposes.
- 8.) To organ procurement organizations or similar entities for the purpose of facilitating transplantations, etc.

- 9.) For medical research that has been approved by an institutional review board or similar medical panel.
- 10.) Where the covered entity in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.
- 11.) For certain specialized government functions including: certain military and veterans activities, certain national security and intelligence activities, protective services for the President and other leaders; certain medical suitability determinations by the Department of State; and certain correctional and law enforcement custodial situations.
- 12.) As authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

The conditions pursuant to which disclosures may be made for the above-listed purposes are more fully described at 45 CFR 164.512.

A covered entity is prohibited from using or disclosing genetic information for underwriting purposes.

Uses and disclosures of protected health information other than those listed, above, may only be made with your written authorization. You may revoke any such authorization by executing a Revocation of Authorization form, a copy of which is available from the Town's Health Benefits Office.

Your Rights

You have the right to inspect and copy your protected health information that is maintained in a designated record set by us. We will provide you with access to this information within thirty (30) days of receiving a written request for it. We will charge a reasonable fee for copying and mailing the records. Your rights with respect to the inspection and copying of records are more fully described at 45 CFR 164.524.

You have the right to request restrictions on certain uses and disclosures of protected health information (as provided at 45 CFR 164.522(a)) to carry out treatment, payment or health care operations. While we are not required to agree to a requested restriction, we will carefully consider any request.

You have the right to request that we allow you to receive communications of protected health information from us by alternative means or at alternative locations if you state that the disclosure of all or part of that information could endanger you. We will accommodate any such reasonable request.

You have the right, subject to certain limitations set forth at 45 CFR 164.526, to request that we amend protected health information, or a record that relates to you, in a designated record set for as long as that information is maintained in the designated record set. Your request to correct, amend, or delete information should be in writing. We will notify you if we make an adjustment as a result of your request. If we do not make an adjustment, we will send you a letter explaining why within 30 days. In the case of a denial, you may ask us to make your request part of your records, or you may file a statement of disagreement with us. You may also file a complaint with us or with the Secretary of Health and Human Services. If we make an amendment we will attempt to inform and provide the amendment within a reasonable time to anyone identified by you as possessing the subject protected health information as well as to persons who we know have the protected health information that has been amended.

You have the right to receive an accounting of the disclosures (if any) of your protected health information that we have made. This right to an accounting does not apply to uses or disclosures that were made in connection with treatment, payment or health care operations, nor does it apply to disclosures that you authorized or to other disclosures listed at 45 CFR 164.528(a). This right to disclosures is more fully described at Section 164.528.

You have the right to be notified when a breach of your unsecured protected health information has occurred.

You have the right to opt out of receiving any fundraising communications. Uses or disclosures of your protected health information for marketing purposes requires your prior written authorization. A disclosure that constitutes the sale of protected health information requires your prior written authorization.

You have the right to obtain upon request a paper copy of this notice from the Town's Health Benefits Office.

General

The Health Plans are required by law to maintain the privacy of protected health information and to provide individuals with notice of the Health Plans' legal duties and privacy practices with respect to protected health information.

The Health Plans are required to abide by the terms of this notice. We reserve the right to change this notice. Any changes to this notice may be effective for all protected health information that the Health Plans maintain. A revised notice will be mailed to you within thirty (30) days of its effective date.

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with our Privacy Official, Dori Vecchio - Human Resources Assistant Director - at (508) 799-1030. Please be assured that you will not be retaliated against for filing a complaint. You may also contact our Privacy Official to receive further information concerning our privacy policies.