

Health and Welfare Benefit Guide

Effective January 2015

**Hourly and Salary
Employees
Of Menasha Corporation**



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Introduction

Menasha Corporation is proud to offer its employees a comprehensive benefits package with a wide range of options based upon individual and family needs. The Company works to provide a benefits program that attracts and retains high-quality employees who are essential to the success of the Company.

The types of benefits available through Menasha have evolved and changed over the past years, as have the way benefits are funded and administered. As part of our ongoing benefits review, we are constantly working to provide employees with competitive and balanced benefits that can meet their financial, healthcare and lifestyle needs while addressing the Company's need to manage escalating healthcare and other benefit costs.

Cultivating an environment where employees are productive and engaged is of primary importance to Menasha. We believe that our continuing efforts to consolidate benefit providers, make design modifications to plans, and offer wellness/prevention programs include progressive actions that will help achieve our goals.

This document is a summary of your health and welfare benefits and should be used in conjunction with the more detailed Summary Plan Descriptions (SPDs). The SPDs will also provide specifics on eligibility and waiting periods for your particular group. This Health and Welfare Benefit Guide, along with the Ancillary Benefit Guide, outlines information about the benefits provided by Menasha Corporation that provide you, your spouse or eligible domestic partner, and your children with valuable insurance products, time off from work, and the means to build financial security for retirement. If you have questions about your benefits, please contact your Human Resources Department.

The Company expects and intends to offer these benefits indefinitely; however, the Company reserves the right to amend or terminate various plans or benefits at any time. Participation in any of the benefit programs does not alter your employment relationship with the Company and is not considered a guarantee of employment. In addition, you may have specific rights with respect to some of these benefits plans through COBRA and/or ERISA. Refer to the SPD for complete COBRA and ERISA rights and details.

The term "spouse" wherever used in this guide includes same-gender spouses, and same-gender and opposite-gender domestic partners. Your domestic partner is the person named in your approved Menasha Affidavit of Domestic Partnership. See the Eligibility section of this document for domestic partner eligibility information.

While we have made every effort to ensure the accuracy of this document, if there are any differences between this document and the Summary Plan Description, the Summary Plan Description will govern.

Medical Benefit Plan

MEDICAL PLAN OPTIONS

Menasha offers two medical plan options. Each plan provides different premiums, deductibles, and coinsurance levels, as well as Company contributions to an HRA or HSA account.

- **HRA Medical Plan** - Partnered with a Health Reimbursement Account (HRA)
- **HSA Medical Plan** - Partnered with a Health Savings Account (HSA)

PREFERRED PROVIDER ORGANIZATION (PPO)

The medical plan options offered by Menasha are PPO plans. In a PPO, a network of hospitals and physicians agree to accept predetermined fees for the health care they provide. You may go to any provider; however, be aware that if the provider you see is not an in-network PPO Provider you will be responsible for increased deductible, coinsurance, and out-of-pocket levels that will apply. In addition, services rendered by a non-PPO Provider are subject to maximum allowed amounts and you may be balance billed to pay the difference.

WAIVE INCENTIVE OPTION

If you elect to not participate in a medical plan, you will be eligible for a Waive Incentive. The incentive is \$15.00 per pay period (up to \$360/year), which will be added to your paycheck and subject to applicable taxes. (Eligible part-time employees receive \$11.25 per pay period.)

DOMESTIC PARTNER COVERAGE

If you are interested in enrolling an unmarried same or opposite-gender domestic partner please ask your Human Resources representative for the Domestic Partner Eligibility and Guidelines document which includes forms you need to complete as well as valuable information you will need to know about your share of contributions which will be after-tax and the amount of the benefit which will be subject to imputed income.

SPOUSE SURCHARGE

If you choose to cover your spouse under Menasha's medical plans and your spouse has access to medical coverage through his or her own employer, you will pay a spousal surcharge of \$37.50 per pay period (\$75 per month). This surcharge will be a pre-tax deduction.

- **The surcharge applies:**
 - If the spouse is enrolled in Menasha's Medical Plan AND has access to employer-sponsored medical benefits through his/her own employer.
- **Surcharge does not apply:**
 - If the spouse is not employed.
 - If the spouse is self-employed and does not have access to employer-sponsored medical coverage.
 - If the spouse's employer does not offer medical coverage.
 - If the spouse is part-time and would be charged a higher premium than full-time employees.
 - If the spouse is also employed by Menasha Corporation.

Women's Health and Cancer Rights Act Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, the Menasha Corporation Basic Benefit Plan provides coverage for: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For more information contact Menasha's Claims Resolution and Health Advocacy Help Line, Concert Health Resources, at (920) 766-7015 or (800-275-8744).

Medical Plans Cost Comparison

Plan Tier	EMPLOYEE COST PER PAY PERIOD			
	HRA		HSA	
	Full-Time Employee and Part-Time Employee (30-39 hours)	Part-Time Employee (20-29 hours)	Full-Time Employee and Part-Time Employee (30-39 hours)	Part-Time Employee (20-29 hours)
EMPLOYEE RATES - NO DISCOUNTS AVAILABLE *				
(Full-Time EE share is 12.5% of the total cost of Medical Coverage)				
Employee Only	\$29.25	\$80.44	\$27.99	\$76.96
Employee + Child/ren	\$56.50	\$155.38	\$53.88	\$148.18
Employee + Spouse	\$59.36	\$163.24	\$56.60	\$155.64
Family	\$87.75	\$241.32	\$83.58	\$229.84
EMPLOYEE RATES - ONE DISCOUNT APPLIED *				
(Full-Time EE share is 10% of the total cost of Medical Coverage)				
Employee Only	\$23.40	\$75.32	\$22.39	\$72.06
Employee + Child/ren	\$45.20	\$145.50	\$43.11	\$138.75
Employee + Spouse	\$47.49	\$152.85	\$45.28	\$145.74
Family	\$70.20	\$225.97	\$66.86	\$215.22
EMPLOYEE RATES - TWO DISCOUNTS APPLIED *				
(Full-Time EE share is 7.5% of the total cost of Medical Coverage)				
Employee Only	\$17.55	\$70.20	\$16.79	\$67.16
Employee + Child/ren	\$33.90	\$135.61	\$32.33	\$129.32
Employee + Spouse	\$35.62	\$142.46	\$33.96	\$135.83
Family	\$52.65	\$210.61	\$50.15	\$200.59

AFFORDABLE CARE ACT FEE				
Rates shown are Per Pay Period				
Employee Only	\$1.67	\$1.91	\$1.67	\$1.91
Employee + Child/ren	\$5.00	\$5.72	\$5.00	\$5.72
Employee + Spouse	\$3.34	\$3.81	\$3.34	\$3.81
Family	\$6.67	\$7.62	\$6.67	\$7.62

Employees are paid bi-weekly, 26 pay periods per year.
However, benefit deductions are only taken 2 times per month, or 24 per year.

DISCOUNTS

- **2.5% discount for participating in Healthy Rewards.** (Menasha's Health Risk Assessment)
 - Employees who were hired before 2/1/14 must have completed in the 2014 Healthy Rewards to be eligible for the discount.
 - Employees hired 2/1/14 and after are automatically eligible for this discount in 2015.
- **2.5% discount for employees who are non-tobacco users or tobacco users who complete the Reasonable Alternative**
 - Tobacco use includes: Cigarette, Chewing tobacco, E-cigarette, Bidis, Cigar, Smokeless tobacco, Hookah, Kreteks and Pipe.
 - Tobacco users can qualify for the 2.5% discount by completing a Reasonable Alternative which will require completion of 3 coaching sessions with Concert Health Resources within a 5 month period.

SPOUSE SURCHARGE

- If you choose to cover your spouse under Menasha's medical plans and your spouse has access to medical coverage through his or her own employer, you will pay a spousal surcharge of \$37.50 per pay period (\$75 per month). This surcharge will be a pre-tax deduction.

Health Reimbursement Account (HRA) vs. Health Savings Account (HSA)

HEALTH REIMBURSEMENT ACCOUNT (HRA) AND HEALTH SAVINGS ACCOUNT (HSA)

If you elect to participate in a company medical plan, Menasha will make a contribution to your HRA or HSA account. The amount of contribution is determined based on which medical plan and which coverage tier you elect. Once accumulated, the funds in your account can be used to pay for health care expenses incurred by you or your qualified dependents that are not eligible for payment by your medical, dental or vision plan.

MENASHA'S PER PAY PERIOD CONTRIBUTION TO YOUR HRA OR HSA ACCOUNT				
Plan Tier	HRA		HSA	
	Full-Time Employee and Part-Time Employee (30-39 hours)	Part-Time Employee (20-29 hours)	Full-Time Employee and Part-Time Employee (30-39 hours)	Part-Time Employee (20-29 hours)
Employee Only	\$30.00	\$22.50	\$25.00	\$19.00
Employee + Child/ren	\$30.00	\$22.50	\$50.00	\$38.00
Employee + Spouse	\$30.00	\$22.50	\$50.00	\$38.00
Family	\$30.00	\$22.50	\$50.00	\$38.00

HEALTH REIMBURSEMENT AND HEALTH SAVINGS ACCOUNT COMPARISON	
HRA	HSA
Differences	
Account is forfeited if you leave employment, (unless you elect COBRA continuation).	The money in your account is yours to keep; you take it with you if you change employers, change health plans or retire.
Unused balances rollover from year to year, up to a maximum balance of \$5,000.	The account balance rolls over from year to year with no maximum limit.
No employee contributions are allowed.	Employee can make pre-tax contributions.
Must complete a claim form to receive reimbursement or sign up for Auto Reimbursement. Eligible for 100% reimbursement of claim.	No claim forms. Use a specially issued debit card to access fund, or use the online Bill Pay feature. Eligible for 100% reimbursement.
Claims for the employee, dependents, and adult children up to age 26 (even if not an IRS dependent) are eligible for reimbursement.	Claims for the employee and IRS qualified dependents are eligible for tax-free reimbursement.
Accounts are administered by Cypress Benefit Administrators.	Accounts are administered by US Bank.
Similarities	
The Company makes contributions to an account based on the medical plan you select. (See above chart)	
Funds in the account can be used to pay for qualified out-of-pocket expenses such as medical, prescription drug, dental, or vision claims which are not covered by Menasha's health plans or other outside insurance.	

You have on-line access to your account balances, reimbursement history and much more.

HRA accounts: are accessed through the Cypress portal at www.wealthcareadmin.com;

HSA accounts are accessed at www.mycdh.usbank.com.

Medical Plan Benefit Comparison

PLAN BENEFIT COMPARISON				
Plan Specifics	HRA		HSA	
	In-Network PPO Provider	Out-Of-Network Provider *	In-Network PPO Provider	Out-Of-Network Provider *
CALENDAR YEAR DEDUCTIBLE				
Individual	\$1,500	\$3,000		
Family	\$3,000	\$6,000		
Employee Only			\$1,500	\$3,000
Employee + Child/ren			\$3,000	\$6,000
Employee + Spouse			\$3,000	\$6,000
Family			\$3,000	\$6,000
	The most deductible any one family member needs to meet is the 'individual' deductible noted above.		There is no separate 'individual' maximum. The whole deductible must be met either by one or a combination of family members.	
COINSURANCE PERCENTAGE				
Company	70%	50%	85%	50%
Employee	30%	50%	15%	50%
ANNUAL COINSURANCE MAXIMUM				
Individual	\$3,500	\$5,500		
Family	\$7,000	\$11,000		
Employee Only			\$3,500	\$5,500
Employee + Child/ren			\$7,000	\$11,000
Employee + Spouse			\$7,000	\$11,000
Family			\$7,000	\$11,000
	The most coinsurance any one family member needs to meet is the 'individual' coinsurance noted above.		There is no separate 'individual' maximum. The whole coinsurance must be met either by one or a combination of family members.	
ANNUAL OUT-OF-POCKET MAXIMUM				
Individual	\$5,000	\$8,500		
Family	\$10,000	\$17,000		
Employee Only			\$5,000	\$8,500
Employee + Child/ren			\$10,000	\$17,000
Employee + Spouse			\$10,000	\$17,000
Family			\$10,000	\$17,000
If there are any differences between this comparison and the Summary Plan Description, the Summary Plan Description will govern.				
<p><i>* Services performed by out-of-network providers are subject to maximum allowed amounts limits.</i></p> <p><i>If your provider charges more than the allowed amount, you may have to pay the difference.</i></p> <p><i>Services provided out-of-network are also subject to Usual, Customary and Reasonable charges.</i></p>				
<p><i>*Out-Of-Network charges for amounts over the maximum allowed amount or as a result of Usual, Customary, Reasonable charges are not included in the maximum deductible or out-of-pocket fees above.</i></p>				

Medical Plan Benefit Comparison

	PARTICIPANT COST			
	HRA		HSA	
	In-Network PPO Provider	Out-Of-Network Provider *	In-Network PPO Provider	Out-Of-Network Provider *
Office Visit (including specialist office visits and x-ray, lab, surgery and anesthesia in office setting)	30% Coinsurance (No Deductible)	Deductible then 50% Coinsurance	Deductible then 15% Coinsurance	Deductible then 50% Coinsurance
Preventive Care / Screening / Immunization Preventive/routine care including: physical exams, Pap and PSA tests, Mammograms, Colonoscopies, hearing exams, vision exams, immunizations, etc.	100% Coverage No Deductible No Coinsurance	100% Coverage No Deductible No Coinsurance	100% Coverage No Deductible No Coinsurance	100% Coverage No Deductible No Coinsurance
If the first time you receive one of the following services during a calendar year and it is coded as diagnostic, the claim will be paid the same as Preventive Care listed above. Otherwise diagnostic services are covered the same as other medical services based on place of service (Office Visit or Outpatient) as outlined in this summary. Pelvic exams, Pap Test, Prostate exams, PSA Test, Mammogram, Colonoscopy or Sigmoidoscopy.				
Preventive Care: Services provided as a routine wellness measure and in the absence of physical complaint or diagnosis.				
Diagnostic Service: Tests or procedures that are performed to determine a definite condition or disease.				
Emergency Care (Expenses in Emergency Room)	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 15% Coinsurance	Deductible then 55% Coinsurance
Note: In emergency situations in-network benefits will apply until you are stabilized and able to be transferred to an in-network				
Inpatient Services (includes room & board, physician visits and services, X-ray and Lab services, anesthesia, therapy)	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 15% Coinsurance	Deductible then 50% Coinsurance
Outpatient Services	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 15% Coinsurance	Deductible then 50% Coinsurance
Skilled Nursing Facility; Home Health Services (See Benefit Maximums below for limitations)	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 15% Coinsurance	Deductible then 50% Coinsurance
Refer to the Summary Plan Description for details on specific services and expenses.				
* Services performed by out-of-network providers are subject to maximum allowed amounts limits. If your provider charges more than the allowed amount, you may have to pay the difference. Services provided out-of-network are also subject to Usual, Customary and Reasonable charges.				
BENEFIT MAXIMUMS				
	Maximum per Individual		Maximum per Individual	
Skilled Nursing Care	120 days per confinement		120 days per confinement	
Home Health Care	160 visits per calendar year		160 visits per calendar year	
Private Room	The facility's Semi-Private rate		The facility's Semi-Private rate	
Lifetime maximum	There is no lifetime Maximum		There is no lifetime Maximum	

Cypress Benefit Administrators: 800.975.0070.

You have on-line access to your medical claims details and much more at: www.cypressbenefit.com.

PPO Medical Networks

2015 MEDICAL PPO NETWORKS BY WORKSITE LOCATION

Location	Network	Location	Network
Arizona	PHCS	Missouri	PHCS
Arkansas	PHCS	New Jersey	Magnacare or PHCS
California	PHCS	North Carolina	PHCS
Colorado	PHCS	Ohio	Ohio Health Choice or PHCS
Florida	First Health Network	Oregon	PHCS
Georgia	PHCS	Pennsylvania	PHCS or Devon Health
Illinois	Health Finest Network	South Carolina	First Health Network or PHCS
Indiana	PHCS	South Dakota	PHCS
Iowa	Midland's Choice Premier	Tennessee	PHCS
Kansas	Health Partners of Kansas	Texas	PHCS
Kentucky	PHCS	Virginia	PHCS
Maryland	PHCS	Washington	PHCS
Massachusetts	PHCS	West Virginia	PHCS
Michigan	PHCS or Cofinity	Wisconsin	HPS / Trilogy
Minnesota	Preferred One	WI - DeForest location only	The Alliance
Mississippi	PHCS		

In addition to the Networks noted above, participants have access to other networks when traveling out of your normal network area; see the National Access card that is issued along with your Health Plan ID card for specific network details across the USA.

Before utilizing a provider it is always good to call or go on-line to verify the provider is in-network!

NETWORK CONTACT INFORMATION

NETWORK	WEBSITE	PHONE
Cofinity	 www.cofinity.net	800.831.1166
Devon Health	 www.devonhealth.com	888.225.8932
First Health Network	 www.myfirstthealth.com	800.226.5116
Health Finest Network (HFN)	 www/hfninc.com	800.295.5444
HPS / Trilogy	 www.hps.md	888.477.7968
Health Partners of Kansas	 www.hpkansas.com	800.633.9917
Magnacare	 www.magnacare.com	800.352.6465
Midland's Choice Premier	 www.midlandschoice.com	800.605.8259
Ohio Health Choice	 www.ohiohealthchoice.com	800.554.0027
PHCS	 www.multiplan.com	866.984.7427
Preferred One	 www.preferredone.com	800.451.9597
The Alliance	 www.the-alliance.org	800.223.4139

Looking for a provider in your PPO network, either call the phone #, or access the website as indicated above.

Prescription Drug Benefit

PartnersRx (Retail) – OptumRx (Mail) – ICORE (Specialty)

If you elect to participate in either the HRA or HSA medical plan you will automatically be enrolled in the Prescription Drug Plan which is included in the medical plan premium and effective the same date as your medical plan coverage.

PRESCRIPTION DRUG BENEFITS - Participant Costs				
PartnersRx (Retail) - OptumRx (Mail Order) - ICORE (Specialty Drugs)				
	HRA MEDICAL PLAN		HSA MEDICAL PLAN	
	Retail	Mail Order	Retail	Mail Order
Maximum supply per fill/refill	90-day supply	90-day supply	90-day supply	90-day supply
Annual Out-of-Pocket Maximum per Individual	\$1,500 (Retail and Mail Order combined)		No separate Rx Out-Of-Pocket Maximum; Rx is included in the Medical Out-Of-Pocket Maximum.	
GENERIC DRUGS, PREFERRED BRAND DRUGS, AND SPECIALTY DRUGS				
Coinsurance	You pay 30%	You pay 30%	Deductible then you pay 30%	Deductible then you pay 30%
Minimum Coinsurance (whichever is less)	\$20 or the cost of the Rx for up to a 31-day supply \$30 or the cost of the Rx for a 32-90-day supply		Deductible, then \$20 or the cost of the Rx for up to a 31-day supply \$30 or the cost of the Rx for a 32-90-day supply	
Maximum Coinsurance	\$60 for a 30-day supply \$120 for a 90-day supply		Deductible, then: \$60 for a 30-day supply \$120 for a 90-day supply	
NON-PREFERRED BRAND DRUGS*				
Coinsurance	You pay 50%	You pay 50%	Deductible, then you pay 50%	Deductible, then you pay 50%
Minimum Coinsurance (whichever is less)	\$20 or the cost of the Rx for up to a 31-day supply \$30 or the cost of the Rx for a 32-90-day supply		Deductible, then \$20 or the cost of the Rx for up to a 31-day supply \$30 or the cost of the Rx for a 32-90-day supply	
Maximum Coinsurance	\$90 for a 30-day supply \$180 for a 90-day supply		Deductible, then: \$90 for a 30-day supply \$180 for a 90-day supply	
Note: The following Preventive Prescription Drugs are not subject to deductible or coinsurance in both the HRA and HSA plans: iron supplements, aspirin, fluoride and folic acid. In addition, in the HSA Plan there are additional Preventive Maintenance Prescription Drugs that are not subject to deductible but are subject to coinsurance.				

***Non-preferred Brand-Name Drugs** – Generally these are Brand-name drugs with alternatives in either the Generic or Preferred Brand Drug category. There are a number of resources to determine if your prescription falls in the Generic, Preferred, or Non-Preferred group.

- Summary document is in the Prescription Drug Benefit section on the Benefit page of InsideMenasha.
- Go to www.partnersrx.com, select 'Members' from the blue bar, then 'Formulary Search' from the menu on the left, and finally click on the PRx Formulary Summary. In this same area select the option to 'Look up your prescription drug's formulary status here'. You will need to enter Menasha's 'Rx Grp #' which is PRXCBE, and finally type in your drug name in the Search bar.
- Call Partners Rx Customer Service Help desk at: 1-800-711.4550

PartnersRx: 800.711.4550; www.partnersrx.com
OptumRx Mail Order Pharmacy: 800.788.4863; www.optumrx.com

Prescription Drug Cost Manager

BidRx

BidRx is a Prescription Drug Cost Manager. BidRx is an alternative to the traditional pharmacy, connecting pharmacies across the country to compete against one another to fill your individual prescription. By using the BidRx website, you can review competitive bids, and then pick the lowest price. You can choose to pick up the prescription at a local retail pharmacy, or have it shipped to you by mail if you find that the lowest price is across the country.



Why use BidRx? - There are substantial savings available if you take the time to research your options at BidRx. This prescription benefit option promotes consumerism. It introduces innovation and savings for members through transparency and competition, but still allows members to choose the option that works best for each prescription.

Incentive –

- When one or more similar products are reported on the Similar Product Price Comparison report for any bid/auction, the lowest cost option is available at \$0.00 coinsurance. **Yes, that's correct, it will be FREE.**
- If you choose a drug that isn't the lowest cost option, your share of the cost will be:
 - 20%, instead of 30% for generic and preferred brand drugs.
 - 40% instead of 50% for non-preferred brand drugs.

All other minimum and maximum coinsurance, deductibles, and out-of-pocket limits apply the same as reported on the prior page for the regular Prescription Drug plan.

Menasha's Benefit Design – Menasha's Rx benefit design has been incorporated into BidRx. So when you use the BidRx assigned username to log in and start an auction/bid, the pricing you see will reflect your actual cost based on whether you are in the HRA or HSA medical plan. Details of the benefit designed are outlined on the prior page of this document.

How to set up your account at www.BidRx.com – All participants enrolled in Menasha's HRA or HSA medical plan receive a letter directly from BidRx which includes the information you need to set up your personal account, as well as some brief instructions for using the website. If you didn't set up your account access yet and have misplaced the letter sent to you with your personalized registration details for the BidRx website, you can contact BidRx Customer Service at 800.470.4491.

BidRx Help – If you have any questions or problems, see the "Frequently Asked Questions" on the "About Us" page on the BidRx site. Customer Service support is also available at 800.470.4491 or e-mail your question to consumersupport@bidrx.com.

BidRx: 800.470.4491; www.bidrx.com

Diagnostic Imaging Cost Manager

One Call Medical



One Call is devoted to managing advanced radiology costs and providing substantial savings to members. The Diagnostic Imaging Program saves you money by providing substantial discounts on MRI, CT and PET procedures whenever you use One Call participating providers.

Contact One Call medical by calling 888-458-8746. Their concierge scheduling service will help find providers in your area, and schedule your appointment. They can also answer any questions you may have about your procedure.

The One Call provider may be right next door, across town, or a short drive away. Using the One Call provider is voluntary and you decide if the cost savings is worth the extra time/drive to use a provider not directly connected to your provider.

One Call Medical: To receive concierge service, call 888.458.8746.

Identity Theft

ICR Bridge



ICR Bridge provides state of the art identity theft resolution services. You and your family now have valuable protection against any form of identity theft.

The resolution service covers each employee, spouse or domestic partner, and all dependents up to the age of 25. If an ID theft breach occurs, just call 866.440.1146 and an ICR representative will fill out your Theft Event Report and put you in contact with your own personal Recovery Expert who will restore your good name. The resolution service is professional, comforting and guaranteed to be 100% effective.

ICR Bridge: 866.440.1146

Medical Management

American Health

Menasha has partnered with American Health to improve outcomes for members while providing savings on health care expenditures. American Health will be providing the following services to Menasha health plan participants. If you are contacted by a representative from American Health you should cooperate with them and welcome their call and intervention.



Case Management – improves the quality of patient care while maximizing cost savings. Case managers are registered nurses and licensed social workers who function as advocates, facilitators and educators, ensuring that members receive appropriate care at the right time, the right setting and the right cost. Case Management includes: Maternity, Neonatal and Pediatric, Oncology, Transplant, Dialysis, and Mental Health.

Utilization Management – provides medical necessity reviews of both inpatient and outpatient procedures to ensure members receive appropriate care while maximizing opportunities for cost savings.

Pre-Admission and Post-Discharge Counseling – These programs are designed to avoid complications and reduce readmissions rates by providing education to members admitted for inpatient procedures.

Disease management program – targets nine prevalent conditions for which evidenced-based guidelines are established to impact health and measure improvements. Members with chronic conditions are identified, and once enrolled work one-to-one with a dedicated nurse health coach. Targeted conditions include: Asthma, Chronic kidney disease, Chronic Pain (osteoarthritis, rheumatoid arthritis or low-back pain), Coronary artery disease, Congestive heart failure, Chronic obstructive pulmonary disease, Diabetes, Hyperlipidemia, and Hypertension.

2015 Precertification Requirements

- **All Inpatient Admissions**
- **Outpatient-Surgery**
 - Back Surgeries
 - Bowel and gastric surgeries
 - Osteochondral Allograft, knee
 - Hysterectomy (including prophylactic)
 - Hearing Implants
 - Procedures related to Chiari's malformation
 - Cosmetic Procedures
- **Outpatient-Diagnostic Services**
 - MRI/MRA, PET, CT
 - Capsule endoscopy
 - Scintimammography
- **Outpatient-Psychiatric and Substance Abuse**
- **Outpatient-Continuing Care Services**
 - Chemotherapy
 - Radiation
 - Dialysis
 - Injectables
 - Hyperbaric Oxygen
 - Outpatient Rehab
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
 - Outpatient Sub-Acute
 - Home Health Care
 - Hospice
 - Durable Medical Equipment

Telephonic Medical Consultation

Teladoc

Teladoc provides access to licensed physicians by phone, video and mobile app. You can get medical advice and treatment any time – 24 hours a day, 7 days a week. **You can avoid the office visit deductible and coinsurance by using Teladoc. There is no cost to you to use Teladoc.** (However, if a prescription is written you will fill that through your local retail pharmacy and pay for it using your ID card in the normal process.)

When should you use Teladoc?

- For non-emergent medical issues, questions, or concerns.
- If your primary care physician is not available or accessible.
- If you're traveling and need medical advice.
- To request a prescription or refill.



The Benefits

- Save time – avoid waiting for an appointment or sitting in a doctor's office or ER.
- Save money – cost reductions compared to doctor's office, urgent care and ER visits.
- Prescription program – Prescriptions and refills available, if appropriate.
- Health portal – Interactive online tools for your health.

Most commonly treated conditions

- Cold/flu
- Sinus and Bronchitis infections
- Upper respiratory infections
- Allergies
- Headaches
- Urinary Tract Infections
- Stomach ache / diarrhea
- Eye and Ear infections
- Rash/skin irritations
- Yeast infection

You will need to set up your account and complete your Medical History Disclosure before receiving a consultation with one of the physicians.

Teladoc: .800.362.2667; www.MyDrConsult.com

Dental Benefit Plan

Delta Dental of Wisconsin

The dental plan consists of a 3-tier plan design:

1. PPO Provider
2. Premier Provider
3. Non-Participating Provider



Dental coverage will vary depending on your dentist's affiliation with Delta Dental as indicated in the chart below. To determine your providers' category contact Delta Dental Customer Service at (800) 236-3712; or www.deltadentalwi.com.

Other than new hires and qualified life events, changes to your dental plan election will only be opened for enrollment on a bi-annual basis. The next open enrollment period will be for the plan year effective 1/1/2017. *(To help protect you from being committed to a plan that might experience a large premium increase, should the premium increase by 10% or more in a 'locked' year, participants would be allowed to exit the plan during that year's open enrollment.)*

PLAN BENEFITS			
	PPO Providers	Premier Providers	Non-Participating Providers
Diagnostic & Preventive	90% *	80% *	60%
Basic Restorative	90%	80%	60%
Major Restorative	50%	50%	50%
Orthodontics (\$1200 lifetime max.)	50%	50%	50%

PLAN LIMITATIONS			
Annual Maximum	\$1,200	\$1,200	\$1,200
Individual Annual Deductible	\$50 *	\$50 *	\$100
Family Annual Deductible	\$100 *	\$100 *	\$200
* The deductible is waived for preventive and diagnostic procedures when performed by Delta PPO or Delta Premier Providers.			

Your pre-tax deduction per pay period:

Employee Only	\$15.41
Employee and Child(ren)	\$30.12
Employee and Spouse	\$31.52
Family	\$51.14

This plan is voluntary; your contribution will be 100% of the cost of the coverage.

Delta Dental: 800.236.3712; www.deltadentalwi.com

Use the Delta website to view your claims, verify copays and deductibles, print ID cards, find in-network dentists, and much more.

Vision Insurance

UnitedHealthcare Vision

This plan provides comprehensive vision care with coverage for lenses and frames, or contacts, with access to over 7,600 retail outlets, or reimbursements are available for out-of-network benefits. A provider listing is available on UnitedHealthcare's website at www.myuhcvision.com.



PLAN BENEFITS AND LIMITATIONS

	Frequency	Network Providers	Out-Of-Network Providers
Vision Exam	12 months	\$10 copay, then 100%	100% up to \$40
<div style="border: 1px dashed black; padding: 10px; text-align: center;"> Reminder: A routine vision exam is also covered under the Menasha Medical Plan Preventive Care benefit. </div>			
Frames	24 months	\$25 copay	100% up to \$45
Frame Benefit is \$130 frame allowance at either a Private Practice or Retail Provider.			
Pair of Lenses	12 months	\$25 copay, then 100%	100% up to \$40 single vision (\$60 Bifocal / \$80 Trifocal / \$80 Lenticular)
Lens Options - Scratch-resistant coating covered in full. Options not covered by the plan: progressive lenses, polycarbonate lenses, high index, tints, UV and anti-reflective coating.			
Contact Lenses (In lieu of Frames & Lenses)	12 Months	\$25 copay, then 100%	100% up to \$125 (elective) 100% up to \$210 (necessary)
Please refer to the UnitedHealthcare Vision brochure for contact lens benefits details.			
Laser Vision Correction	UHC partners with the Laser Vision Network of America and LasikPlus Vision Centers to provide access to discounted laser vision correction procedures. To find out more about the Lasik program or to find a participating laser vision correction surgeon in your area, visit the website at www.uhclasik.com , or call 1-888-563-4497.		

Your pre-tax deduction per pay period:

Employee Only	\$3.08
Employee and Child(ren)	\$5.92
Employee and Spouse	\$5.61
Family	\$9.53

This plan is voluntary; your contribution will be 100% of the cost of the coverage.

UnitedHealthcare Vision: 800.638.3120 ; www.myuhcvision.com

Use the UHC website to view your claims, verify copays and deductibles, print ID cards, find in-network providers, and much more.

Basic Term Life Insurance

The Basic Term Life Insurance Plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. (Employees with Basic Life Insurance amounts over \$50,000 will see imputed income on your pay statement taxing any amount over \$50,000.)

BASIC TERM LIFE BENEFIT

The amount of coverage
is equal to your annual base wage,
rounded up to the next \$1,000;
with a minimum coverage level of \$35,000.

Basic Accidental Death & Dismemberment Insurance (AD&D)

The Basic Accidental Death and Dismemberment (AD&D) Insurance Plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death, or for you in the event of any other covered loss such as loss of a limb, speech, hearing, or sight.

BASIC AD&D BENEFIT

The amount of coverage
is equal to your annual base wage,
rounded up to the next \$1,000;
with a minimum coverage level of \$35,000.

Both the Basic Term Life and Basic AD&D are 100% Company-paid benefits

Part-time employees are not eligible for basic term life or basic AD&D insurance.

Voluntary Term Life Insurance

You can choose additional term life insurance coverage for yourself, your spouse or domestic partner, and your dependent child(ren). During your initial eligibility period the maximum coverage available without Evidence of Insurability is: Employee - \$300,000; Spouse - 50,000; and Child(ren) - \$10,000.

If you waive coverage during your initial eligibility period, you can elect coverage during an annual open enrollment period; however, you will be required to complete and be approved through Evidence of Insurability (EOI) for all levels of coverage. In addition, at annual open enrollment EOI is required if you choose an option more than 1 level above your current election.

EMPLOYEE OPTIONS

Employee Coverage Maximum is \$500,000 or 5 times compensation, whichever is less.	\$ 10,000	\$ 100,000	\$ 250,000
	\$ 20,000	\$ 125,000	\$ 300,000
	\$ 30,000	\$ 150,000	\$ 350,000
	\$ 40,000	\$ 175,000	\$ 400,000
	\$ 50,000	\$ 200,000	\$ 450,000
	\$ 75,000	\$ 225,000	\$ 500,000

SPOUSE OR DOMESTIC PARTNER OPTIONS

Spouse/DP coverage maximum is \$250,000 or 100% of the Employee's Voluntary Term Life amount, whichever is less.	\$ 10,000	\$ 75,000	\$ 175,000
	\$ 20,000	\$ 100,000	\$ 200,000
	\$ 30,000	\$ 125,000	\$ 225,000
	\$ 40,000	\$ 150,000	\$ 250,000
	\$ 50,000		

DEPENDENT CHILD(REN) OPTIONS

The life insurance benefit paid for a child from birth to 6 months is \$1,000.	\$ 2,000	\$ 6,000	\$ 10,000
	\$ 4,000	\$ 8,000	

The employee must elect Voluntary Term Life in order to enroll in either the spouse or child Voluntary Term Life benefits.

Your after-tax deduction per pay period:

Employee and Spouse Rate:

Is dependent on age and tobacco usage. See the chart to the right.

Dependent Child(ren) Rate:

\$0.084 per \$1,000 of coverage

These plans are voluntary. Your contribution will be 100% of the cost of the coverage.

Age	Does not Use Tobacco	Tobacco User
< 24	\$ 0.042	\$ 0.058
25 – 29	\$ 0.041	\$ 0.058
30 – 34	\$ 0.042	\$ 0.064
35 – 39	\$ 0.055	\$ 0.089
40 – 44	\$ 0.075	\$ 0.132
45 – 49	\$ 0.120	\$ 0.211
50 – 54	\$ 0.185	\$ 0.356
55 – 59	\$ 0.305	\$ 0.506
60 – 64	\$ 0.463	\$ 0.721
65 – 69	\$ 0.820	\$ 1.216
70 – 74	\$ 1.481	\$ 2.264
75 – 99	\$ 2.962	\$ 3.822
Per \$1,000 of coverage		

Voluntary AD&D Insurance

You can choose accidental death and dismemberment (AD&D) insurance coverage for yourself, your spouse or domestic partner, and your dependent child(ren). AD&D insurance covers accidental loss of life, hands, feet, sight, speech, and hearing.

If you waive coverage during your initial eligibility period, you can elect coverage during an annual open enrollment period. Once you are enrolled in any of the Voluntary AD&D options you may change the coverage option during an annual open enrollment period.

Covered Losses	
Covered Loss	Benefit
Loss of: life; 2 or more hands or feet; sight in both eyes; loss of one hand or one foot and sight in one eye; speech and hearing; Quadriplegia; Coma	100%
Paraplegia	75%
Loss of: one hand or foot; sight in one eye; severance and reattachment of one hand or foot; speech; hearing in both ears; Hemiplegia	50%
Loss of: four fingers of the same hand; thumb and index finger of the same hand; Uniplegia;	25%
See the Summary Plan Description for more details about the benefits paid and covered losses.	

EMPLOYEE OPTIONS			
Employee Coverage	\$ 10,000	\$ 100,000	\$ 250,000
Maximum is \$500,000	\$ 20,000	\$ 125,000	\$ 300,000
or 15 times	\$ 30,000	\$ 150,000	\$ 350,000
compensation,	\$ 40,000	\$ 175,000	\$ 400,000
whichever is less.	\$ 50,000	\$ 200,000	\$ 450,000
	\$ 75,000	\$ 225,000	\$ 500,000

SPOUSE OR DOMESTIC PARTNER OPTIONS			
Spouse/DP amount of	\$ 10,000	\$ 75,000	\$ 175,000
AD&D may not be	\$ 20,000	\$ 100,000	\$ 200,000
more than 100% of the	\$ 30,000	\$ 125,000	\$ 225,000
Employee's amount of	\$ 40,000	\$ 150,000	\$ 250,000
Voluntary AD&D	\$ 50,000		
coverage.			

DEPENDENT CHILD(REN) OPTIONS			
	\$ 10,000	\$ 40,000	\$ 75,000
	\$ 20,000	\$ 50,000	\$100,000
	\$ 30,000		

Your after-tax deduction per pay period:

Employee Rate:

\$0.011 per \$1,000 of benefit

Spouse Rate:

\$0.0125 per \$1,000 of benefit

Dependent Child(ren) Rate:

\$0.0125 per \$1,000 of benefit

These plans are voluntary. Your contribution will be 100% of the cost of the coverage.

The employee must elect Voluntary AD&D
in order to enroll in either the spouse or child Voluntary AD&D benefits.

Basic Long Term Disability (LTD) Insurance

Long Term Disability Insurance provides monthly compensation in the event that you become disabled and are unable to work. Monthly benefits will start after completion of a 180-day elimination period.

LTD Benefit	Maximum Covered Monthly Salary	Maximum Benefit Available Per Month
60% of your salary	\$8,333	\$5,000
When calculating your individual benefit, if your monthly salary is above the maximum noted above, use the maximum from the chart instead of your actual monthly salary.		
Pre-Existing Condition Limitation: If you file a claim for LTD benefits within the first 12 months of coverage there will be a look back several months prior to your enrollment to determine whether you had a pre-existing condition.		

This Basic Long-Term Disability Insurance is 100% Company-paid.

(This basic LTD coverage is a taxable benefit; therefore, you will see imputed income on your pay statement for the value of your Basic LTD benefit.)

Voluntary Long Term Disability (LTD) Insurance

You may purchase an additional 10% of Long-Term Disability Insurance coverage, for a total of 70% of your salary which includes the Company-paid benefit indicated above.

LTD Benefit	Maximum Covered Monthly Salary	Maximum Benefit Available Per Month	Rate Per \$100 of covered monthly salary
70%	\$12,000	\$8,400	\$0.31
Per Paycheck Premium Calculation: Your Monthly Salary Times .0031 = Your per month premium (divide by 2 to find the premium per pay)		Monthly Benefit Calculation: Your Monthly Salary Times 70%	
When calculating your individual premium and/or benefit, if your monthly salary is above the maximum noted in this chart, use the maximum from the chart instead of your actual monthly salary.			
This plan is voluntary. Your premium is 100% of the cost of the 70% buy-up plan.			
<u>Pre-Existing Condition Limitation:</u> If you file a claim for LTD benefits within the first 12 months of coverage there will be a look back several months prior to your enrollment to determine whether you had a pre-existing condition. If you decline coverage for the Voluntary LTD when you are first eligible and then elect to enroll at a later date, you are considered a Late Entrant in the plan and are subject to a pre-existing condition limitation. This means if a claim were to occur within the first 24 months of coverage there will be a look back 12 months prior to your enrollment to determine whether you had a pre-existing condition.			

Group Voluntary Critical Illness Insurance

Allstate Benefits

You can choose Critical Illness insurance coverage for yourself, your spouse or domestic partner, and your dependent child(ren). Below is a listing of covered illnesses and benefit amounts for the 3 options available.

Covered Illnesses and Eligible Benefit

Critical Illness (Amount of Benefit Paid)	Low Option	Medium Option	High Option
Heart Attack; Stroke; Coma; Paralysis; Major Organ Transplant; End Stage Renal Failure; Invasive Cancer or Benign Brain Tumor; Complete Blindness or Loss of Hearing (100%)	\$10,000	\$20,000	\$30,000
Coronary Artery By-Pass Surgery ; Advanced Alzheimer's; Advanced Parkinson's; Carcinoma in Situ (25%)	\$2,500	\$5,000	\$7,500
Wellness Benefit (Per Year, per covered person)	\$50	\$50	\$50

The wellness benefit will be paid for a large variety of wellness screenings including blood tests, cancer screenings, heart tests, etc. See the detailed Allstate Benefit document for a complete listing.

The amount show above is the Employee Benefit amount.
Covered dependents are eligible for 50% of the employee benefit amount.

Cost Per Pay Period

\$10,000 OPTION		EE Only and EE+CH tiers		EE+SP and Family tiers	
Age		Non-tobacco User	Tobacco User	Non-tobacco User	Tobacco User
18-29		\$2.67	\$3.91	\$4.32	\$6.18
30-39		\$4.68	\$7.25	\$7.33	\$11.18
40-49		\$8.54	\$15.06	\$13.11	\$22.89
50-59		\$15.04	\$25.34	\$22.87	\$38.32
60-63		\$24.36	\$41.69	\$36.86	\$62.85
64+		\$31.85	\$55.05	\$48.08	\$82.89
\$20,000 OPTION		EE Only and EE+CH tiers		EE+SP and Family tiers	
Age		Non-tobacco User	Tobacco User	Non-tobacco User	Tobacco User
18-29		\$4.72	\$7.21	\$7.39	\$11.12
30-39		\$8.74	\$13.87	\$13.41	\$21.11
40-49		\$16.46	\$29.48	\$25.00	\$44.54
50-59		\$29.47	\$50.04	\$44.50	\$75.38
60-63		\$48.10	\$82.75	\$72.46	\$124.44
64+		\$63.07	\$109.47	\$94.91	\$164.51
\$30,000 OPTION		EE Only and EE+CH tiers		EE+SP and Family tiers	
Age		Non-tobacco User	Tobacco User	Non-tobacco User	Tobacco User
18-29		\$6.76	\$10.49	\$10.45	\$16.04
30-39		\$12.78	\$20.49	\$19.48	\$31.04
40-49		\$24.37	\$43.91	\$36.87	\$66.18
50-59		\$43.88	\$74.75	\$66.12	\$112.43
60-63		\$71.84	\$123.81	\$108.07	\$186.02
64+		\$94.28	\$163.89	\$141.74	\$246.14

The Age band is determined when you first enroll, and remains constant as long as you maintain the same level of coverage, even if your age changes to a new level in future years. (For Example: if you are age 39 and purchase the Low Option, your premium is based on age 39 this year and every year going forward as long as you maintain that same Low Option coverage level. However, if in a future year you move to the Medium or High Option, that starts a new coverage and the age you are when you make the change now becomes your new static age level.)

This benefit will be offered with guarantee issue to all employees who elect coverage during annual open enrollment for 1/1/2015 and 1/1/2016. Starting in 2017 employees enrolling for the first time or moving up a coverage level during annual enrollment will be subject to pre-existing condition health questions. New hires will have guarantee issue during their initial enrollment period and not be subject to pre-existing condition health questions.

Group Voluntary Off-The-Job Accident Insurance

Allstate Benefits

You can choose Voluntary off-the-Job Accident coverage for yourself, your spouse or domestic partner, and your dependent child(ren). Below is a listing of the covered accidents and benefits and payment amounts.

Covered	Benefit Amount		
	Employee	Spouse (if covered)	Child(ren) if covered
Accident Death or Dismemberment	\$60,000	\$30,000	\$15,000
Common Carrier Accident Death	\$300,000	\$150,000	\$75,000
Dislocation or Fracture	\$6,000	\$3,000	\$1,500

Covered	Benefit Amount
Coma with Respiratory Assistance	\$10,000
Hospitalization Confinement (per Year)	\$1,500
Open Abdominal or Thoracic Surgery	\$1,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage	Surgery - \$500; Exploratory - \$150
Ambulance Services	Regular - \$300; Air - \$900
Paralysis	Paraplegia - \$7,500; Quadriplegia - \$15,000
Burns	<15% of body - \$100; 15% or more of body - \$500
Prosthesis	1 device - \$500; 2 or more devices - \$1,000
Ruptured Disc Surgery	\$500
X-Ray; Emergency Room Services	\$300
Accident Physician treatment; Brain Injury diagnosis	\$150
Appliance	\$125
Eye Surgery, General Anesthesia, Blood and Plasma	\$100
Lacerations; CT/MRI Scans	\$50
Medical Supplies or Medicine	\$5
Intensive Care (per day)	\$600
Daily Hospital Confinement (per day)	\$300
Physical Therapy (per day)	\$30
Rehabilitation Unit (per day)	\$100
Non-local Transportation (per trip)	\$400
Family Member Lodging (per day)	\$100
Post-Accident Transportation	\$200
Accident Follow-up Treatment (per day)	\$50
Outpatient Physician Benefit	\$75; Up to 2 times per year for EE only coverage Up to 4 times per year for EE + dependent coverage

This benefit is paid when a covered person is treated by a physician outside of a hospital for any cause. Please review the Allstate Benefit document for a complete listing of some exclusions to this Outpatient Physician Benefit including visits related to a job accident, self-inflicted injury; illegal activity; drug or alcohol related; active military; etc.

Coverage is Guarantee Issue; no pre-existing condition health questions will be asked.

Cost Per Pay Period			
Employee Only	Employee + Spouse	Employee + Child(ren)	Family (EE+SP+CH)
\$8.51	\$12.45	\$17.19	\$21.49

*Allstate Benefits (AB) is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

Allstate-Menasha specific website: www.allstatevoluntary.com/allstatevoluntary/menasha/

Flexible Spending Accounts (FSA)

A Flexible Spending Account is a means for you to set aside some of your wages pre-tax into an account which you can then use to pay for eligible out-of-pocket expenses for yourself and your dependents including your adult children up to age 26.

There are 2 different kinds of accounts:

- **Health Care FSA** – Can be used for health care costs such as copays, deductibles, coinsurance, and other expenses not covered by your health plans. Medical, dental and vision claims are all eligible. Over-the-counter drugs are not eligible for reimbursement unless prescribed by a physician or for Insulin. Other over-the-counter equipment and supplies, such as braces, bandages, and contact lens solution are eligible expenses.
- **Dependent Care FSA** – Can be used for expenses incurred to care for dependents to enable you to work.

Some additional properties of an FSA:

- The money is set aside in an account that only you can access.
- You choose an annual election amount that will be taken in equal amounts from 24 paychecks throughout the year.
- Any money left in the account at the end of the plan year will not roll over into the next year and will be lost.
- There is a 90-day period after the plan year ends to request reimbursement for expenses, as long as the date of service or receipt is within the plan year just ended.
- An FSA election is effective for the entire plan year and can only be changed in the event of a qualified life event that would affect an FSA election.
- Maximum Annual Contribution Limits:
 - **Health Care FSA:** \$2,500
 - **Dependent Care FSA:** \$5,000 (Note this is a combined maximum for married couples.)

IMPORTANT NOTE TO PARTICIPANTS IN THE HSA MEDICAL PLAN: Only dental and vision expenses are eligible for reimbursement under the Health Care FSA until the current year HSA medical plan deductible has been met.

FSA accounts: are accessed through the Cypress portal at www.wealthcareadmin.com.
You have on-line access to your account balances, reimbursement history and much more.

Pre-Tax Premium / Section 125

Several benefits are paid under Section 125 of the IRS Code, which allows your contributions to be made with pre-tax earnings. To take advantage of this tax benefit you must elect to participate in the plans before your initial eligibility date. The plans eligible for pre-tax contributions include Medical, Spouse Surcharge, Dental, Vision, and Health Care and Dependent Care Flexible Spending Accounts.

Auto Reimbursement

Auto Reimbursement is a behind-the-scenes electronic process that automatically transfers participants' eligible out-of-pocket medical and prescription drug expenses for reimbursement from your Health Care Flexible Spending Account (FSA) or Health Reimbursement Account (HRA). Eligible claims are those related to deductible, or coinsurance, that are the participant's responsibility. (If a claim is considered an ineligible charge it is not processed through Auto Reimbursement.) This auto reimbursement process eliminates the need for participants to submit manual claim forms and supporting documentation.

Only participants in the HRA medical plan are eligible to participate in Auto Reimbursement. (If you waive medical coverage or elect the HSA plan, Auto Reimbursement is not available.) Also, claims from Delta Dental and UnitedHealthcare Vision are not able to be processed via Auto Reimbursement; you would still need to manually file dental and vision claims.

Claims will be reimbursed at 100%. When you are enrolled in both an FSA and HRA you can choose which account the claims will be processed against:

- Option #1 - Against the FSA first; then when FSA is exhausted, processed to the HRA
- Option #2 - Only against the FSA
- Option #3 - Only against the HRA

Your Auto Reimbursement processing choice will be locked in until the next open enrollment and cannot be changed mid-year.

Employee Health Advocacy Help Line Concert Health Resources



- Do you have medical or dental questions?
- Are you looking for a family doctor that fits your personal needs?
- Do you need help finding a specialist within your PPO network?
- Do you need assistance with claims resolution?
- Is there anything you can do about denied charges?
- Are you wondering if there is a more cost effective provider/drug/procedure?
- Are you having difficulty understanding the prescription drug plan?
- Have you received a diagnosis that you want more information about?

Dr. John Butitta, M.D. and Virginia Schuller-Rach, R.N. at Concert Health Resources can help you. They will listen to your needs and work as your advocate. They are knowledgeable about the insurance industry, understand coding and billing practices and can speak one-on-one with doctors regarding your particular needs.

There is no cost to you to access the services of Concert Health Resources. Menasha pays 100% of the premium.

Concert Health Resources: 800.275.8744 (or 920.766.7015).
To access your on-line health risk assessment: <https://secure.concerthealth.net>.

Qualified Life Events

As a participant in the Pre-Tax Premium Plans (Medical, Dental, Vision, etc.) you are eligible to make changes to your benefit elections without waiting for the next annual open enrollment period if you experience a qualified mid-year life event and provided that you request the change within 30 days after the qualified life event.

QUALIFIED LIFE EVENTS

- Marriage / divorce.
- Birth / adoption / legal guardianship change.
- Change in domestic partner status.
- Change in a dependent's eligibility.
- Death of spouse or other covered dependent.
- Change of spouse or domestic partner's employment resulting in gain or loss of coverage.
- Change in spouse's access to medical coverage resulting in a change to the spouse surcharge.
- A significant change in your spouse or domestic partner's, medical coverage or cost (20% or more).
- Termination or change in status of your spouse or domestic partner that results in gain or loss of employer-sponsored group coverage.
- Daycare provider change (change allowed to dependent care FSA only).

SPECIAL ENROLLMENT OPPORTUNITY

In addition to the above qualified life events, a special enrollment opportunity is available if you, or your eligible spouse or domestic partner, or child either lose or become eligible for a state's premium assistance program under Medicaid or CHIP coverage.

WHAT YOU SHOULD DO?

If you experience one of the above Qualified Life Events you must notify your Human Resources Department and complete the Life Event Change Form within 30 days of the Qualified Life Event (or within 60 days in the case of Medicaid or CHIP coverage).

- Changes are retroactive to the date of the life event.
- Changes must be consistent with the life event.
- You will be required to provide documentation to verify the life event.

WHAT IF THE NOTIFICATION ISN'T COMPLETED WITHIN 30 DAYS OF THE QUALIFIED LIFE EVENT?

- If you were requesting to add or remove a benefit or a dependent – Your request will be denied and you will not be able to make the change until the next open enrollment period. (Except in the case of a birth or adoption, the child will be added to the benefit plan as of the birth or adoption date and the premium change will also be made retroactive to the date of birth or adoption.)
- If you are removing an ineligible dependent – The dependent would be removed the date he/she is no longer eligible and the premium deduction will be corrected on a prospective basis from the date of notification.
- If you are correcting a spouse surcharge – the change will be made and surcharge deduction corrected on a prospective basis from the date of notification.

IT IS EXTREMELY IMPORTANT THAT QUALIFIED LIFE EVENTS ARE REPORTED WITHIN 30 DAYS OF THE LIFE EVENT.

DO NOT DELAY SUBMITTING A LIFE EVENT FORM WAITING FOR OFFICIAL DOCUMENTS. In all cases you may submit alternative documentation with the Life Event Form to meet the 30 day deadline and then follow up with official documents later.

Contact your local HR representative for questions with regard to Life Events.

Dependent Eligibility

'Dependent' is a reference to those eligible for coverage based on their relationship to the employee participant, not on IRS tax dependency. Dependents eligible for coverage under Menasha's health and welfare plans include those listed below. Employees adding a spouse or child to one of their health plans will be required to provide documentation to show the person being added meets Menasha's Eligibility requirements. See the listing of acceptable documents on the next page.

Claims under Menasha's plans will only be paid for dependents you have enrolled who meet the eligibility requirements for the Plan. You are responsible for maintaining accurate information on eligible dependents.

Eligible Dependents:

- Spouse
 - Includes both opposite-gender and same-gender legally married spouses.
- Domestic Partner (unmarried same or opposite gender partners) as named in your approved Menasha Affidavit of Domestic Partnership. If your partnership is not established under state laws, you and your domestic partner must meet the following Menasha criteria in order to be eligible for company benefits.
 - Have an exclusive, committed relationship of mutual caring.
 - Share the same principal residence for at least the prior 12 months and intend to do so indefinitely.
 - Be at least 18 years of age and mentally competent to consent to contract.
 - Be jointly responsible for each other's common welfare and living expenses.
- Child under age 26
 - Your biological child
 - Your lawfully adopted child
 - A child placed for adoption with you
 - A child for whom you are legal guardian
 - Your step-child
 - A child of your domestic partner same as defined in the preceding bullet points, only if the domestic partner is also enrolled in the benefit plan. (Note: The domestic partner's child is NOT considered a 'dependent child' for COBRA purposes.)

[A grandchild is NOT eligible unless he/she fits the definition of your child in the above bullet points. (i.e. You are legal guardian for, or have adopted the grandchild.)]

No person may be covered both as an employee and as a dependent.

- When both a parent and child are employed by Menasha, the child can continue to be enrolled under the parent's health plans if the child is under 26 years of age and waives his own coverage options. The employed child would not be eligible to be covered under the Parent's Voluntary Child Life or Voluntary Child AD&D plans.
- When both spouses are Menasha employees, they cannot be enrolled under each other's Voluntary Spouse Life or Voluntary Spouse AD&D plan.

No person may be covered as a dependent of more than one employee.

- When both parents are Menasha employees, dependent children can only be enrolled for health and welfare plan coverages under one parent.

Required Documentation to show Dependent Eligibility For Health Plan Participation (Medical, Dental, Vision)

Employees adding a spouse or child to one of the health plans will be required to provide documentation, as outlined below, to show the person being added meets Menasha's Dependent Eligibility requirements.

For Spouse

- A copy of your marriage certificate

AND one of the following if you were married more than 60 days ago:

- A copy of the front page of the most recent year's federal tax return confirming this dependent is your spouse.
- A document dated within the last 60 days showing current relationship status such as a recurring household bill or statement of account. The document must list your spouse's name, the date and your mailing address.
Note: Healthcare bills will not be accepted as proof of eligibility.

ALSO If the spouse is enrolled in the Menasha medical plan and indicated that the Spouse Surcharge does not apply

- An Affidavit of Spouse/Domestic Partner Health Care Coverage.

For Domestic Partner

- A Menasha Affidavit of Domestic Partnership or government-issued Declaration of Domestic Partnership.

AND

- A document dated within the last 60 days showing current relationship status such as a recurring household bill or statement of account. The document must list your partner's name, the date and your mailing address.

ALSO If the domestic partner is enrolled in the Menasha medical plan and indicated that the Spouse/Domestic Partner Surcharge does not apply

- An Affidavit of Spouse/Domestic Partner Health Care Coverage.

For Children up to age 26

- A copy of the child's state-issued birth certificate (hospital birth records are not accepted) or adoption certificate naming you or your spouse as the child's parent (first and last names listed).

OR

- A copy of the court order naming you or your spouse as the child's legal guardian.

Note for a stepchild: If you are covering a stepchild or child of your domestic partner you must also provide documentation of your current relationship to your spouse or domestic partner as requested above.

Disabled Child over age 26

- One of the documents listed above for children up to age 26.

AND

- Physician statement certifying that the dependent child is incapable of self-sustaining employment due to a mental or physical disability that began prior to the child's 26th birthday.
- Statement indicating the child receives more than half of his/her support from the employee.

Contact Information

If You Have Questions Concerning	Contact	Contact Information
<ul style="list-style-type: none"> Medical/Dental Claims Resolution General Medical/Dental Questions 	Concert Health Resources Employee Advocacy Help Line	920.766.7015 800.275.8744
<ul style="list-style-type: none"> Medical Claims Medical PPO Provider Networks Specific Medical Benefit Coverage Questions COBRA 	Cypress Benefit Administrators	920.968.0070 800.975.0070 www.cypressbenefit.com
<ul style="list-style-type: none"> HRA Account HRA Claim/Reimbursement FSA Account FSA Claim/Reimbursement 	Cypress Benefit Administrators	View account balances at: www.cypressbenefit.com or www.wealthcareadmin.com Submit reimbursement requests via scan and e-mail to: menasha@cypressbenefit.com Or by fax to 920.968.4616
<ul style="list-style-type: none"> Prescription Drug Claims 	PartnersRx (Retail) OptumRx (mail) and BidRx	800.711.4550 www.partnersrx.com 800.470.4491 www.bidrx.com
<ul style="list-style-type: none"> Dental Claims Dental PPO Provider Network Coverage under the Dental Plan 	Delta Dental of Wisconsin	800.236.3712 www.deltadentalwi.com
<ul style="list-style-type: none"> Vision Claims Vision PPO Provider Network 	UnitedHealthcare Vision	800.839.3242 www.myuhcvision.com
<ul style="list-style-type: none"> HSA Account HSA Distribution 	US Bank	877.470.1771 www.healthsavings.usbank.com
<ul style="list-style-type: none"> Off-The-Job Accident Insurance Critical Illness Insurance 	Allstate Benefits	
<ul style="list-style-type: none"> Identity Theft 	ICR Bridge	866.440.1146

Health Cost Managers

<ul style="list-style-type: none"> Medical Cost Manager (Currently limited to Wisconsin) 	Alithias	www.alithias.com/menasha
<ul style="list-style-type: none"> Prescription Drug Cost Manager 	BidRx	www.bidrx.com
<ul style="list-style-type: none"> Virtual Healthcare 	Teladoc	800.362.2667 www.myDrConsult.com
<ul style="list-style-type: none"> Diagnostic Imaging 	One Call	888.458.8746

Important Notice about Your Prescription Drug Coverage and Medicare

(Employees and/or Dependents Who Are Medicare Eligible)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Menasha Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 17th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Menasha Corporation coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Menasha Corporation coverage, be aware that you and your dependents will be able to get this coverage back at the next annual enrollment period or if you have a qualified life event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Menasha Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

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

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

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

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

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

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

Date: 10/1/14
Name of Entity/Sender: Menasha Corporation
Contact--Position/Office: Sr. Benefit Analyst, 1645 Bergstrom Road, Neenah, WI 54956, 920.751.116

Privacy Notice

Menasha Corporation - Basic Benefit Plan

Address: 1645 Bergstrom Road, Neenah, WI 54956; Website: www.menasha.com

Privacy Officer contact: CorporateHR@menasha.com; 920.751.1163

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

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

→ **Get a copy of health and claims records**

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

→ **Ask us to correct health and claims records**

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

→ **Request confidential communications**

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

→ **Ask us to limit what we use or share**

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

→ **Get a list of those with whom we’ve shared information**

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

→ **Get a copy of this privacy notice**

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

→ **Choose someone to act for you**

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

→ **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

→ Help manage the health care treatment you receive

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

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

→ Run our organization

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

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

→ Pay for your health services

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

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

→ Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

→ Help with public health and safety issues

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

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

→ Do research

- We can use or share your information for health research.

→ Comply with the law

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

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

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

→ Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

→ Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notice.html.

Changes to the Terms of this Notice

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

Notice Of COBRA Continuation Coverage Rights

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: your local Human Resources representative.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Cypress Benefit Administrators, Attention: COBRA Department, P O Box 7020, Appleton WI 54912-7020, 877.236.0844

CERTIFICATE OF CREDITABLE COVERAGE

Should your medical coverage end with Menasha for any of the above reasons, a Creditable Coverage Certificate will be issued that shows when your (and your dependents if applicable) health coverage (creditable coverage) with Menasha ended. The certificate will be issued automatically and free of charge when you lose coverage under a plan, when you are entitled to elect COBRA continuation coverage or when you lose COBRA continuation coverage. The Certificate of Creditable Coverage will be included in the packet of information you receive from Menasha's COBRA Administrator. Or a certificate will also be provided free of charge upon request while you have health coverage or within 24 months after your coverage ends. You can contact your local HR Rep or the Corporate Benefits department to request the Creditable Coverage Certificate.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your human resources representative.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: Menasha Corporation	4. Employer Identification Number (EIN): 39-1367484
5. Employer address: 1645 Bergstrom Road	6. Employer phone number: 800.558.5073
7. City: Neenah	8. State: WI
	9. ZIP code: 54956
10. Who can we contact about employee health coverage at this job: Corporate Employee Benefits; 800.558.5073	
11. Phone number (if different from above):	12. Email address: CorporateHR@Menasha.com

Here is some basic information about health coverage offered by this employer: As your employer, we offer a health plan to some employees. With respect to dependents: We do offer coverage.

☒ If checked, this coverage meets the minimum value standard

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Benefit Express - On-line Benefits Enrollment

Information and enrollment in Menasha Corporation's benefit programs can be accessed through an on-line enrollment system called Benefit Express.

To enroll in the Health & Welfare Benefit Plans initially, and annually thereafter, you will access this website which is set up to automatically guide you through the enrollment process. After the initial enrollment, you can view your benefit elections at any time as well as review and change your beneficiary information.

Go to: www.menashabenefits.com

Log on using your preset User Name and Password as indicated below. You will be prompted to change your password as soon as you log in. (Or select the "Change Password" option on the home screen. Your password must be 6-12 characters in length.)

User Name = LLLLLLF1234 - First 6 letters of your last name (if your last name has less than 6 letters, just use your full last name), the first letter of your first name and the last 4 digits of your Social Security Number. Do not use any hyphens, dashes, apostrophes, or spaces.

Password = MMDDYYYY - Your initial password is your date of birth. You will be prompted to change your password as soon as you log in (or navigate to the "Change Password" link under "My Data"). Your password must be 6-12 characters in length.

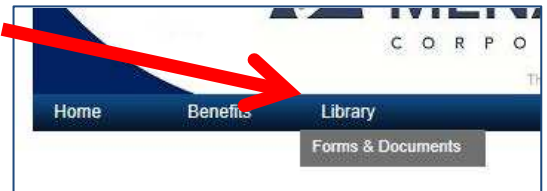
Benefits Information Resources

There are more documents detailing the specifics of Menasha's Benefit plans available to help answer your questions. The documents are available at the following:

Benefit Express Library

www.menashabenefits.com

Select Forms & Documents
from the Library drop down list.



Inside Menasha

Select Pay and Benefits
from the InsideMenasha home screen.



Benefits Mobile App

www.menasha-navigator.com/2014/mobile