



2016

OPEN ENROLLMENT BOOKLET

**The Year 2016 Open Enrollment Period Runs From
OCTOBER 19, 2015 through NOVEMBER 6, 2015**

Department of Employee Relations

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***ALL ACTIVE CITY OF MILWAUKEE
EMPLOYEES MUST RE-ENROLL IN HEALTH
INSURANCE ON SELF SERVICE***

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Other Benefit Information available on-line at www.milwaukee.gov/der/benefits2016

➤ **Group Life**

- ◆ Basic Group Life – all general city employees working **more than 20 hours per work** will automatically be provided \$50,000 in City paid life insurance (excludes Fire & Police).
- ◆ Voluntary Group Life Insurance – is additional coverage that an employee may enroll in that is entirely paid for by the employee.
- ◆ Family Life Insurance – is additional coverage that an employee may enroll in that covers the employee’s family (spouse or domestic partner and dependent children).
- ◆ Note: Employees on the self-service system must enroll in Voluntary Life Insurance on-line. HACM and Wisconsin Center District employees must complete a paper application to enroll.



WHAT'S NEW IN 2016?

ALL ACTIVE EMPLOYEES MUST RE-ENROLL IN HEALTH INSURANCE ON SELF SERVICE OR COMPLETE A WAIVER FORM.

- **UnitedHealthCare** – UW-Madison Hospital and Physicians are now in-network with UnitedHealthCare – Choice & Choice Plus Plan.
- **High Deductible Health Plan** – The City will offer a high deductible health plan for active full-time City employees. See page 10 for more details.
- **CarePlus Dental (Dental Associates)** – has a new center Milwaukee –Beerline B located at 220 E. Pleasant Street.
- **Flexible Choices Program** – Total Administrative Services Corporation (formerly Eflexgroup, Inc.) is the Flexible Choice Administrator. **At some point members will receive a new debit card.**
- **Healthy Rewards in 2016** – To be eligible for a \$250 Health Reimbursement Account (HRA) you must complete the 3 step Wellness Your Choice Milwaukee program (lab work, online health questionnaire and 30 minute coaching session). The Healthy Rewards Program runs from July 1, 2015 through June 30, 2016. Employees and spouses/partners earning 100 points through biometrics and various activity/programs will qualify for a \$250 HRA. These funds work just like a FSA account. For more information, see page 22 or visit our website www.milwaukee.gov/der/Benefits2016/hr.
- **Workplace Clinic** – For a second year, Workforce Health offers the services of an on-site Nurse Practitioner. These services are available to employees and their spouses at no cost. The office is located in the Ziedler Municipal Building (use Market Street entrance). For more information, see page 35 or visit our website www.milwaukee.gov/der/wywm.
- **Life Insurance** – If you are not currently enrolled in Voluntary Life Insurance and you intend to retire and would like to have life insurance while retired, you must enroll. Evidence of Insurability (EOI) will be required. For additional information, please contact Employees' Retirement System at (414) 286-3557.
- **Affordable Care Act (ACA)** – In 2016 all full-time and limited benefit employees will need to show verification of health insurance coverage. The City will mail employees a new tax form to submit with annual tax forms that shows health insurance coverage. Employees who do not have coverage through the City or through a spouse/other family member will be subject to financial penalties under the ACA.

HEALTH & DENTAL OPEN ENROLLMENT

Annual Open Enrollment - October 19, 2015 through November 6, 2015

The City's Annual Open Enrollment period is upon us once again. The rates may influence your health plan choice for the year 2016. Please go online to www.milwaukee.gov/der/benefits2016 to see the rate chart for the employee share of the premium. The City will pay 88% of the lowest cost plan in 2016 for general city employees; premiums for public safety employees will be in accordance with applicable labor agreements. The benefit design including but not limited to the deductibles, co-pays, co-insurance and out of pocket maximums employees must pay may be changed for 2016 for any particular group of employees, including public safety employees, based on Common Council action.

This is your only opportunity during the year to make a change to your health or dental plan for plan year 2016. Review the information in this booklet, especially the plan comparison tables (beginning on page 7). If you want more information about a particular plan, call the health or dental plan directly. Their phone numbers and websites are on page 51. You may also pick up plan information packets at the Open Enrollment Fairs as listed on page 4, or at the Department of Employee Relations in City Hall Room 706.

All Active employees will use the online Employee Self Service Program to make benefit changes. The system is accessed with a web browser at work or home. Login on the Internet at <https://prd.com.mycmsc.com>, and then click HRMS PRD 9.1. All employees must have their Employee ID Number and a Password. To request or reset a password, go to www.Milwaukee.gov/rits.

HEALTH PLANS - YEAR 2016

United Healthcare will administer two self-funded health plans for the City of Milwaukee:

UHC CHOICE PLAN - The City's self-funded EPO Plan with deductible and co-insurance, 1-800-841-4901, www.myuhc.com

UHC CHOICE PLUS PLAN – The City's self-funded PPO Plan with higher deductibles, co-insurance and higher premiums, 1-800-841-4901, www.myuhc.com.

HIGH DEDUCTIBLE HEALTH PLAN (Active City Full-Time Employees) – The City will offer a high deductible health plan in 2016.

DENTAL PLANS - YEAR 2016

The City has contracted with three dental plans in 2016; they are listed below:

- **CarePlus Benefit Plans, Inc.**
- **Anthem-Dental Blue**
- **MetLife Dental**



Open Enrollment Fairs

The City will hold six (6) Open Enrollment Fairs that are open to all City employees and retirees. The schedule is listed below.

Tuesday, October 20th - 1:00 p.m. to 4:00 p.m. Hillside Family Resource Center
..... 1452 North 7th Street

Thursday, October 22nd - 9:00 a.m. to 1:00 p.m. City Hall Rotunda
..... 200 East Wells Street

Tuesday, October 27th - 1:30 p.m. to 5:30 p.m. Wilson Park Senior Center
..... 2601 West Howard Avenue

Thursday, October 29th - 3:00 p.m. to 6:00 p.m. Fire and Police Academy
..... 6680 North Teutonia Avenue

Tuesday, November 3rd - 1:00 p.m. to 4:30 p.m. DPW Field Headquarters
..... 3850 North 35th Street

Thursday, November 5th - 9:00 a.m. to 1:00 p.m. City Hall Rotunda
..... 200 East Wells Street



NOTICES

➤ **Notice to New Employees**

All new employees to the City of Milwaukee will have a thirty day (30) waiting period for health and dental benefits. New employees must enroll through the self service program within 30 days of their City start date. If you're enrolling in health/dental insurance and adding a spouse; domestic partner, dependent children and domestic partner children, you must submit a copy of the marriage certificate, birth certificate and include the social security number for each dependent enrolling in benefits.

➤ **Notice to Employees Regarding the Thirty-Day Rule:**

You must enter the Life Event changes **within 30 days** of births and marriages (including marriage to another City employee) through self-service. You must submit a copy of the marriage certificate, birth certificate and include social security number for each dependent enrolling in benefits. Non-compliance with this Thirty-Day Rule may expose you to additional costs. There will be no exceptions to this rule.

Active employees are responsible for keeping their enrollment status current. Login on the Internet to <https://prd.com.mycmsc.com> then click HRMS PRD 9.1. All employees must have their Employee ID number (6-digits) and a Password. To request or reset a password go to www.milwaukee.gov/rits.

➤ **Notice to Employees regarding the One-Family Plan Rule:**

City employees who are married to each other may only carry one health plan and one dental plan between them. One spouse may carry both health and dental plans, or one spouse may carry the health plan and the other spouse may carry the dental plan. You are required to report your marriage to another city employee within 30 days of the date of your marriage. There may be financial penalties if you fail to report your marriage.

City of Milwaukee Management employees whose spouse is employed by another governmental agency may only be enrolled in a family coverage with the City of Milwaukee or with their spouse's employer, but not both.

➤ **Notice to Employees Separating from the City**

Active employees separating from the City are eligible to have their insurance through **the end of the following month after their separation**. Discharges will have coverage through **the end of the month of the discharge**. Members receiving health and dental benefits through the end of the following month are responsible for the employee share of the premium. **If your payment has not been deducted on your paycheck for the final month, you will be billed.**

➤ **Domestic Partners and children**

Domestic Partner medical benefits are available for all City employees. City employees must be in a registered Domestic Partnership in order to be eligible for these benefits. The children of the domestic partner are also eligible for benefits. There are tax implications associated with the benefits. Call **Vaughn Brooks, Employee Benefits at 286-2178** or visit our website www.milwaukee.gov/der/benefits2016 for additional information.

➤ **Hospital and Physician Quality**

The UHC Premium Tier 1 designates a list of physicians who offer better health outcomes, higher quality and competitive costs. Members receive an incentive to use Premium Tier 1 Providers with their co-insurance remaining at 10%. Members can use Non Premium Tier 1 Providers, but will pay a 30% co-insurance. For more information about Premium Tier 1 Providers go to www.myuhc.com or see page 11 for more information.

DISCLAIMER:

Receiving this booklet does not necessarily imply you are eligible for City health and/or dental coverage. Only persons eligible under labor contract provisions, Common Council resolutions, or COBRA may enroll. In making these various plans available, the City of Milwaukee is not endorsing the selection of a particular plan or the level of benefits or quality of care offered by a particular plan. It is the responsibility of the employee to carefully review the plan and to make a decision based on this review. This material was prepared and sent with the cooperation of the City's health and dental plans.



IMPORTANT TAX INFORMATION FOR ALL EMPLOYEES

AFFORDABLE CARE ACT (ACA) UPDATE

All active full-time and limited benefit employees are offered a qualifying health benefits plan (or health insurance) by the City of Milwaukee. Under the Affordable Care Act (ACA) all employees are required to have health insurance coverage. If a City employee wishes to waive health insurance coverage in 2016, regardless if he/she waived in the past, the employee will be required to complete a “waiver form” during open enrollment. The forms are available for downloading on the DER website, www.milwaukee.gov/der/benefits2016 or in City Hall, Room 706.

By early February 2016, all employees will receive a 1095C form (Employer-Provided Health Insurance Offer and Coverage) in the mail. This form demonstrates the employee has health insurance coverage through the City of Milwaukee. 2015 is the first year that the City will report to the IRS every employee who has health insurance coverage, and likewise every employee will have a statement showing they have health insurance coverage through the City. More information about this will be available during open enrollment.

Employees who do not have other health insurance coverage through a spouse or other family member will be subject to Affordable Care Act and any financial penalties associated with not having health insurance.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE*

NOTE: This summary is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. The Summary Plan Description shall prevail.

*The benefit design may change during 2016, based on Common Council action.

Type of Coverage	CITY OF MILWAUKEE UHC CHOICE PLAN	CITY OF MILWAUKEE UHC CHOICE PLUS PLAN	
	Network Only Benefits	Network Benefits	Non-Network Benefits
1. Annual Deductible – (Employee Pays) Individual Deductible Family Deductible	\$ 750 per year \$1,500 per year	\$1,500 per year \$3,000 per year	\$3,000 per year \$6,000 per year
2. Co-Insurance – (Employee Pays) Individual Family	10% or 30% up to \$750 10% or 30% up to \$1,500 per family not to exceed \$750 per member.	10% or 30% up to \$1,500 10% or 30% up to \$3,000 per family not to exceed \$1,500 per member.	30% up to \$3,000 30% up to \$6,000 per family not to exceed \$3,000 per member.
3. Out-of-Pocket Maximum for Health – (Employee Pays) (Includes both deductible & co-insurance) Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	\$1,500 per year \$3,000 per year	\$3,000 per year \$6,000 per year	\$ 6,000 per year \$12,000 per year
4. Emergency Health Services (Employee Pays) (The ER co-pay applies to the out of pocket maximum).	\$200 co-pay per visit.	\$200 co-pay per visit.	\$200 co-pay per visit.
5. Physician Fees for Surgical & Medical Services **Increases to 90% for UHC Premium Tier 1 Provider.	70%** after Deductible met **Increases to 90% for UHC Premium Tier 1 Provider.	70%** after Deductible met. **Increases to 90% for UHC Premium Tier 1 Provider.	70% after Deductible met.
6. Physician Office Services – Sickness & Injury **Increases to 90% for UHC Premium Tier 1 Provider.	70%** after Deductible met. **Increases to 90% for UHC Premium Tier 1 Provider.	70%** after Deductible met. **Increases to 90% for UHC Premium Tier 1 Provider.	70% after Deductible met.
7. Preventive Care Services (Plan Pays) Include Preventive Care Visit, Lab, or other preventive test. Generally, when a service is performed during your preventive care visit and had rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, and there are no known symptoms, illnesses or history, the services will be considered for this benefit. For more information about preventive services that might be for you, visit www.uhcpreventivecare.com .	100% Deductible does not apply.	100% Deductible does not apply.	Not Covered.
8. Prescription Drug Benefits - administered by Optum RX. The employee pays: Retail Pharmacy – 30 day supply Mail Order – up to 90 day supply (The prescription co-insurance does not apply to the deductible or medical out of pocket maximum).	20% co-insurance (minimum \$4 & maximum \$75). 20% co-insurance (20% of the total cost of a 3 month supply. Minimum \$8 & maximum \$150.)	20% co-insurance (minimum \$4 & maximum \$75). 20% co-insurance (20% of the total cost of a 3 month supply. Minimum \$8 & maximum \$150.)	Not Covered. Not Covered.
9. Out-of-Pocket Maximum for Prescriptions – (Employee Pays)	\$3600	\$3600	Not Covered.

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Type of Coverage	CITY OF MILWAUKEE UHC CHOICE PLAN	CITY OF MILWAUKEE UHC CHOICE PLUS PLAN	
	Network Only Benefits	Network Benefits	Non-Network Benefits
10. Lifetime Maximum	No Lifetime Maximum.	No Lifetime Maximum.	No Lifetime Maximum.
11. Benefit Plan Co-Insurance – Amount the Plan pays for #11 - #31	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
12. Ambulance Services – Emergency & approved Non-Emergency	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
13. Autism Spectrum Disorder Services	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
14. Dental Accident/Oral Surgery (UHC-Choice members must use in-network providers). Oral Surgery coverage is limited to 13 specific oral surgical procedures. (See end of benefit summary on pg. 9).*	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
15. Durable Medical Equipment	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
16. Hearing Aids Benefits are limited to enrolled dependent children under 18 years of age. Limited to one hearing aid per ear every 3 years.	90% after Deductible met	90% after Deductible met.	70% after Deductible met.
17. Home Health Care Benefits are limited to 40 visits per calendar year.	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
18. Hospice	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
19. Hospital – Inpatient Stay	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
20. Lab, X-Ray & Diagnostics - Outpatient	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
21. Mental Health Services	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
22. Rehabilitation Services – Chiropractic Treatment	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
23. Rehabilitation Services – Outpatient Therapy Short-term outpatient rehabilitation for Physical therapy, Occupational therapy, Speech therapy, Pulmonary rehabilitation therapy, Cardiac rehabilitation therapy, and Respiratory therapy. 50 visit maximum per year for each necessary therapy.	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE*

NOTE: This summary is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. The Summary Plan Description shall prevail.

*The benefit design may change during 2016, based on Common Council action.

Type of Coverage	CITY OF MILWAUKEE UHC CHOICE PLAN	CITY OF MILWAUKEE UHC CHOICE PLUS PLAN	
	Network Only Benefits	Network Benefits	Non-Network Benefits
24. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services. 120 day maximum per inpatient stay.	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
25. Substance Use Disorder	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
26. Temporomandibular Joint disorder Treatment (TMJ) Benefits are limited to \$1,250 per year for diagnostic procedures and non-surgical treatment.	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
27. Transplant Services	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
28. Urgent Care	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
29. Vision Care One routine vision exam per year. Optometrist Ophthalmologist **Increases to 90% for UHC Premium Tier 1 Provider. For more information about in-network physicians, visit www.myuhc.com .	90% after Deductible met. 70%**after Deductible met. **Increases to 90% if UHC Premium Tier 1 Provider.	90% after Deductible met. 70%**after Deductible met. **Increases to 90% if UHC Premium Tier 1 Provider.	Not Covered. Not Covered.
30. Nutritional Counseling Dietitian Physician **Increases to 90% for UHC Premium Tier 1 Provider.	90% after Deductible met. 70%**after Deductible met. **Increases to 90% for UHC Premium Tier 1 Provider.	90% after Deductible met. 70%**after Deductible met. **Increases to 90% for UHC Premium Tier 1 Provider.	70% after Deductible met. 70% after Deductible met.
31. Prosthetic Devices	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
32. Dependent Coverage	Include employee's spouse; domestic partner, eligible dependent children, stepchildren, foster children, grandchildren (if the parent is an eligible dependent child under the age of 18), domestic partner's children, adopted children and children placed for adoption as mandated by the State or Federal government. Based on the Affordable Care Act, coverage for dependent children is through the end of the calendar year in which the dependent child turns 26, without regard to the child's school status, marital status or dependent status.		

United Healthcare Oral Surgery is limited to the following 13 oral surgical procedures. UHC-Choice members must use in-network providers (see #14 on page 8).

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. Surgical removal of bony impacted teeth; 2. Excision of tumors, cysts of the jaws, cheeks, lips, tongue, roof of mouth when such conditions require pathological examination; 3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of mouth; 4. Apicoectomy; 5. Excision of exostosis of jaws and hard palate; 6. Treatment of fractures of facial bones; | <ol style="list-style-type: none"> 7. External incisions and drainage of cellulitis; 8. Incision of accessory sinuses, salivary glands or ducts; 9. Gingivectomy; 10. Alveolectomy; 11. Frenectomy; 12. Removal of retained root; 13. Gingival and Apical curettage. |
|---|---|

City of Milwaukee

High Deductible Health Plan (HDHP) for Active City Employees

The City's High Deductible Health Plan (HDHP) will have a benefit design and coverage that is **VERY DIFFERENT** from the UHC-Choice and Choice Plus plans, including the following. **Please review carefully before selecting this plan.**

In-Network Providers: Members selecting the HDHP will need to use in-network providers for all covered services and will use the UHC Choice Network panel of providers.

Combined Deductible: Members selecting the HDHP will have a combined \$1,500 (single) and \$3,000 (family) deductible for their medical and prescription drugs. If the member selects family, one person in the family may be responsible for the entire \$3,000 family deductible, unlike other city plans.

Co-Insurance: Members selecting the HDHP will have a \$1,500 (single) and \$3,000 (family) co-insurance for medical services. If the member selects family, one person may be responsible for the entire \$3,000 co-insurance.

Out of Pocket Maximum (OOP max): Members selecting the HDHP will have a \$3,000 (single) and \$6,000 (family) combined medical and prescription drug OOP max. If the member selects family, one person in the family may be responsible for the entire \$6,000 family OOP max.

Prescription Drugs: Members selecting the HDHP will pay 100% for prescription drugs as part of a joint medical and prescription drug deductible and OOP max. After the member or family deductible for medical and prescription drug cost (\$1,500 or \$3,000) is met, then member will pay 20% of the total cost for prescription drugs until the OOP max (\$3,000 or \$6,000) is met. There are no minimum or maximum costs for prescription drugs with the HDHP. The combined HDHP deductibles and OOP max do apply.

Emergency Room: Members selecting the HDHP will pay 100% for emergency room services until their full single/family deductible is met. After the deductible is met, the member will be responsible for co-insurance until their \$3,000 or \$6,000 OOP max is met.

Preventive Care: Preventive services are covered at 100% without deductible and OOP max, but must be submitted with appropriate preventive coding.

Premium Tier 1 Providers: Members selecting the HDHP will have a 70% co-insurance if they see a non-Tier 1 Premium provider or 90% co-insurance if they see a Tier 1 Premium provider.

Qualified High Deductible Health Plan: The plan is a qualified high deductible health plan that allows a member to set up a health savings account (HSA). The City **will not** be contributing to a member's HSA.

The rates for the HDHP are on the DER website at www.milwaukee.gov/der/benefits2016.

WELCOME.

You are enrolled in UnitedHealthcare

powered by
UnitedHealth
PREMIUM

YOUR UNITEDHEALTHCARE CHOICE PLAN FEATURES

You save money by choosing a UnitedHealth Premium[®] Tier 1 physician.

You can reduce your out-of-pocket costs by using UnitedHealth Premium Tier 1 physicians. Please review this document or visit UnitedHealthPremium.com for more information about the Premium program.

You can choose any doctor or hospital in our network.

You can save money when you choose doctors (including specialists), hospitals and pharmacies in the network. If you receive care outside of our network, the plan will not cover the cost. Emergencies are covered anywhere in the world.

You do not need a referral to see a specialist.

See any network doctor, including specialists, without referrals.

SERVICES COVERED

- ▶ Doctor office visits
- ▶ Emergency services
- ▶ Hospital care
- ▶ Lab services
- ▶ Mental health and substance use disorder services
- ▶ Outpatient care services
- ▶ Pregnancy and newborn care
- ▶ Prescription drugs
- ▶ Preventive care services
- ▶ Rehabilitative services and devices
- ▶ Wellness services

This is not a complete list of the services covered under this plan. See your summary of benefits and coverage for details.

Note: If you enroll in UnitedHealthcare Choice Plus plan you can choose any doctor or hospital. Your premium, deductible, co-insurance and out-of-pocket maximum will be higher. Please see open enrollment booklet for details.

Introducing UnitedHealth Premium Tier 1

From finding a doctor, to evaluating treatment options, to understanding the cost of care, consumers are looking for comparative information. The UnitedHealth Premium program can help. When you're looking for a doctor, you can consider his or her Premium designation when making your choice.

TIER 1

Look for the UnitedHealth Premium Tier 1 symbol to quickly and easily find doctors who have been recognized for providing value.

 **UnitedHealth Premium Tier 1**
 Estimated Distance: 0.6 miles
 128 HOSPITAL DR,
 WATERLOO, WI 53098-3304
 920-262-4925
[Map](#) | [Additional Location](#) | [Add Contact](#) | [Text Me](#)
[Report Inexact Info](#)

About UnitedHealth Premium Tier 1

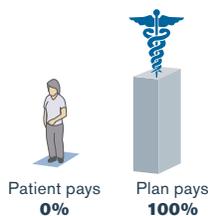
UnitedHealth Premium Tier 1 physicians have received the Premium designation for:

- ▶ Quality & Cost Efficiency OR
- ▶ Cost Efficiency & Not Enough Data to Assess Quality



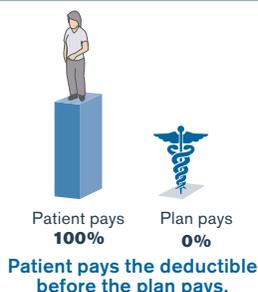
HOW THE PLAN WORKS

1 Covered Preventive Care Services are paid at 100%.

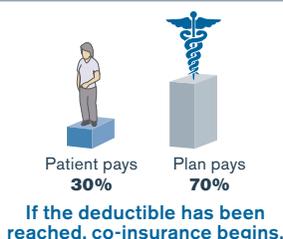


Plan pays 100% of covered preventive services *must be submitted with appropriate preventive coding.

2 You will have a **deductible** for most services.¹ The deductible is the amount of money you pay for covered services before your plan starts to pay.



3 After you meet your deductible, you will have to pay **co-insurance**.¹ Co-insurance is when the plan shares the cost of expenses with you. The plan will pay a percentage of each covered service, and you will pay the rest. For example, your plan pays 70% of the cost, you will pay 30%.



4 Your share of the cost will be lower when you visit UnitedHealth Premium Tier 1 physicians, specialists or surgeons. Your plan co-insurance increases to 90% when you use a UnitedHealth Premium Tier 1 physician, meaning you will only pay 10% co-insurance.



5 You are protected with an **out-of-pocket limit**. This is the most you will have to pay during a policy period (calendar year) for covered services. If you reach the limit, the plan will pay 100% of your eligible covered services for the rest of the policy period.²



Choose with confidence.

The Premium program is one of the longest-running physician quality and cost-efficiency designation programs in the industry, and we continue to make changes that enhance the program and deliver greater value. We share this information with you to help you make informed choices about your care.

UnitedHealth Premium specialties

Allergy
 Cardiology
 Cardiology – Electrophysiology
 Cardiology – Interventional
 Ear, Nose and Throat (ENT)
 Endocrinology
 Family Practice
 Gastroenterology
 General Surgery
 General Surgery - Colon/Rectal
 Internal Medicine
 Nephrology
 Neurology
 Neurosurgery – Spine
 OB-GYN
 Ophthalmology
 Orthopaedics – General
 Orthopaedics – Foot/Ankle
 Orthopaedics – Hand Orthopaedics
 Orthopaedics - Hip/Knee
 Orthopaedics - Shoulder/Elbow
 Orthopaedics - Spine
 Orthopaedics - Sports Medicine
 Pediatrics
 Primary Care Physician Pulmonology
 Rheumatology
 Urology

Physician designations are subject to change. Before you make an appointment, we recommend that you visit myuhc.com[®] and check your doctor's Premium designation.

For certain services, you may be required to have approval before those services can be covered by your plan. **See your benefit plan documents for details on covered services.**



¹ This payment will not apply for eligible preventive care expenses.

² Co-payments, co-insurance and the deductible are included in the out-of-pocket limit.

The UnitedHealth Premium[®] designation program is an information resource to help you choose a physician. It may be used as one of many factors you consider when choosing the physicians from whom you receive care. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. Like many performance assessment programs, physician evaluations have a risk of error. Please see myuhc.com[®] for detailed program information and methodologies. Designations are displayed in UnitedHealthcare on-line physician directories at myuhc.com. You should always consult myuhc.com for the most current designation information.

Information for individuals residing in the state of Louisiana or who have policies issued in Louisiana: Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of these fees for those non-network services, in addition to applicable amounts due for co-payments, co-insurance, deductibles, and non-covered services. Specific information about network and non-network facility-based physicians can be found at myuhc.com or by calling the toll-free Customer Care telephone number that appears on the back of your health plan ID card.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

FAQ: Using your pharmacy benefits



Your pharmacy benefits help you get the right medication at a reasonable price. Take a few minutes to better understand the features and programs in your pharmacy plan. It can help you to get the most from your benefits when making medication decisions with your doctor.

Who is OptumRx?

OptumRx is your plan's pharmacy benefit manager (PBM). Your plan sponsor chose us to manage and process your pharmacy claims. We will also answer your pharmacy benefit questions and tell you about programs offered in your plan.

How do I find a participating retail pharmacy?

Your plan's pharmacy network includes thousands of chain and independent pharmacies nationwide. To find one near you, visit our website, myuhc.com. Then select **Manage My Prescriptions** and **Get Started**. Or call the customer service number on the back of your ID card.

FAQ: Using your pharmacy benefits

How do I fill a prescription at a pharmacy?

There are several ways to fill prescriptions at your pharmacy:

- **Option 1:** Your doctor can call or fax your prescription to the pharmacy.
- **Option 2:** Your pharmacist can call your doctor to ask for a refill request.
- **Option 3:** Visit your retail pharmacy to request a refill or give them a new prescription written by your doctor.

How do I find out which medications are covered by my plan?

A Prescription Drug List (PDL) is a list of brand-name and generic medications covered by your plan. These medications are the best value in quality and price, so using them can help control rising drug costs for you and your benefit plan sponsor.

You can find the most up-to-date PDL at **myuhc.com**. Or call Customer Service at the number on the back of your ID card. To learn more about your pharmacy benefit coverage, including copayments or coinsurance, please see your plan documents.

Why should I show my ID card when I fill a prescription?

Your pharmacy uses information on your ID card to send your prescription claim to OptumRx to process. Showing your ID card also ensures that you pay the lowest possible cost.

Even when using a low-cost generics program, you should show your ID card. If the generic drug costs less than your copayment or coinsurance, you pay the smaller amount.

If your plan has a deductible, showing your ID card allows your cost to go toward meeting the deductible.

Can I order medications through home delivery?

If your plan includes home delivery, you can get up to a 90-day supply of your maintenance medication(s) from OptumRx.

To choose home delivery, use any of the following options:



By online registration:

Visit **myuhc.com**, register and follow the simple step-by-step instructions. You can manage your medication online, including filling new prescriptions and transferring other prescriptions to home delivery. You can also set up text message reminders to help manage your medication schedule. Be sure to have your health plan ID card and medication bottles on hand.

**By phone:**

Just call the member phone number on the back of your plan ID card to talk with a customer service representative right now. It's helpful to have your plan ID card and medication bottle available. The representative can also contact your doctor directly if you need a new prescription.

**By mail:**

Ask your doctor for a new prescription for up to a three-month supply, plus refills for up to one year. Then go to **myuhc.com** and download the new prescription order form. Mail it to the address provided on the bottom of the form.

**By fax / ePrescribe:**

Ask your doctor to call **1-800-791-7658** for instructions on how to fax your prescription directly to OptumRx. Or your doctor can send an electronic prescription to OptumRx.

How long does it take to get my order through home delivery?

Refills should arrive in about seven business days after OptumRx receives your order. New orders should arrive in about 10 business days. There is no cost to you for standard delivery. Overnight delivery is available for an additional charge.

How do I order refills through home delivery?

You have four ways to order refills from OptumRx:

- Order online at **myuhc.com**
- Call our automated phone system
- Call customer service at the number on the back of your ID card
- Complete the reorder form inside each medication shipment and send it to us for processing

Remember, by registering at our website, you'll receive email reminders when it is time to refill your prescriptions.

Are generic medications as good and safe as brand-name drugs?

Yes. Every generic medication is equivalent to the brand-name medication. They both have the same strength, purity and quality. Both brand-name and generic medications meet U.S. Food and Drug Administration (FDA) standards for safety and effectiveness.

What tools are available on the OptumRx website?

Our website, **myuhc.com**, is easy to use and offers a fast, safe and secure way to refill home delivery prescriptions, manage your account, get drug information and pricing, and more. Registration is free and there are no extra fees to order home delivery prescriptions online. Once you register, you can visit our website anytime to use these and other great tools:

- **Medication Reminders** — Sign up to get text messages and emails that remind you to refill or take your medications. Our online refill calendar gives you, family members and caregivers helpful alerts.
- **Medicine Cabinet** — Open up your virtual medicine cabinet to see the status of your prescriptions, review past orders and list any over-the-counter drugs you take.
- **Claims History** — View your prescription claims processed by OptumRx.

When can I refill my prescriptions?

You can usually refill prescriptions after you use about two-thirds of the medication. For example, when taken as prescribed:

- 30-day prescriptions may be refilled after 23 days
- 90-day prescriptions may be refilled after 68 days

Can I get permission to refill my medication early, such as before I go on vacation?

If your plan allows early refills in special cases, call customer service at the number on your ID card. Ask for an early refill authorization.

How do I request a prior authorization?

Certain medications may require special approval from your plan to be covered. This is called prior authorization. If your doctor prescribes one of these medications, you, your pharmacist or doctor can begin the review process by calling customer service. A customer service advocate will work with your doctor's office to get the information for a prior authorization review.



OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum™ company — a leading provider of integrated health services. Learn more at **optum.com**.

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Discover the convenience of OptumRx[®] Mail Service Member SelectSM



Mail Service Member Select is a home delivery program that makes it easy for you to receive your ongoing medications by mail. This program will save you time and help you better manage the medication you take regularly. Not only is home delivery safe and reliable, it also offers the following advantages:



Cost savings: You may pay less for your medication with a three-month supply through OptumRx.



Convenience: Get free standard shipping on medications delivered to your mailbox.



24/7 access and reminders: Speak to a pharmacist who can answer your questions any time, any day. Even set up text and email reminders to help you remember to take or refill your medications.*

Choose your fill preference

You can choose to fill your maintenance medication through either OptumRx or a retail pharmacy. If you choose a retail pharmacy, you must disenroll from the Mail Service Member Select program.

The program allows you two retail pharmacy fills of your maintenance medication before you must choose. If you do not take action after the second retail fill, you may pay more for your medication until you make a decision.

Making the choice

To choose home delivery, use any of the following options.



By online registration:

Visit **myuhc.com**[®], and select *Manage My Prescriptions*. You can manage your medication online, including filling new prescriptions and transferring other prescriptions to home delivery. You can also set up text message reminders to help manage your medication schedule. Be sure to have your health plan ID card and medication bottles on hand.



By phone:

Just call the member phone number on the back of your plan ID card to talk with a customer service representative right now. It's helpful to have your plan ID card and medication bottle available. The representative can also contact your doctor directly if you need a new prescription.



By mail:

Ask your doctor for a new prescription for up to a three-month supply, plus refills for up to one year. Then go to **myuhc.com** and download the new prescription order form. Mail it to the address provided on the bottom of the form.



By fax / ePrescribe:

Ask your doctor to call **1-800-791-7658** for instructions on how to fax your prescription directly to OptumRx. Or your doctor can send an electronic prescription to OptumRx.

To disenroll from Mail Service Member Select, contact OptumRx by calling the member phone number on the back of your ID card or visit **myuhc.com**—within the pharmacy section you can manage your mail service options under **My Account**. Here you will be able to disenroll from the Mail Service Member Select Program.

*OptumRx provides this service at no cost. Standard message and data rates charged by your carrier may apply.



OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum[™] company — a leading provider of integrated health services. Learn more at **optum.com**.

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City of Milwaukee Diabetic Benefits for Actives

Diabetic Claims (Equipment and Supplies) Claims Adjudication Processes

Non-Medicare Actives	
Item	Claim Adjudication
Durable Medical Equipment (DME) to include insulin pumps and the supplies used for insulin pumps.	<p>Processed through the medical benefit for both UHC Choice and UHC Choice Plus (See #15 on the Summary Benefit Table on pg. 8)</p> <p>Glucose meters and insulin pumps are covered at 90% co-insurance after satisfying deductible.</p>
Diabetic testing supplies to include test strips, syringes, lancets, etc.	<p>Processed through the pharmacy benefit for both UHC Choice and UHC Choice Plus.</p> <ul style="list-style-type: none"> • All members have a 20% co-insurance (minimum \$4 and maximum \$75) for diabetic testing supplies through OptumRX. • All members have a 20% co-insurance for mail orders. 20% of the total cost of a 3 month supply (minimum \$8 and maximum \$150) for diabetic testing supplies through OptumRX.

Preventive Health Guidelines

The importance of preventive healthcare

Remember the old saying that “an ounce of prevention is worth a pound of cure.” This can be especially true when it comes to preventive health care. And, better health may lower your health care costs.

Maintaining or improving your health is important; and a focus on regular preventive care, along with following the advice of your doctor, can help you stay healthy. Routine checkups and screenings can help you avoid serious health problems, allowing you and your doctor to work as a team to manage your overall health.

What is preventive care?

Preventive care focuses on maintaining your health, and establishing your baseline health status.

Even if you’re in the best shape of your life, serious conditions with no signs or symptoms may put your health at risk. Through a preventive exam and other routine health screenings, your doctor can detect the early warning signs of more serious issues to provide early treatment.

New online tool

At www.uhcpreventivecare.com you can identify your age and gender-specific preventive care recommendations allowing you to help manage your health and reach your overall health goals.

You can use this information to talk with your doctor to make health decisions that meet your lifestyle and daily habits and help you live a healthier life.

It’s easy and fast.

“Wellness Your Choice Milwaukee”

The City of Milwaukee partners with Froedtert Health Workforce Health to provide comprehensive health and wellness services to City employees. The 3-step program includes a blood draw, an online Health Questionnaire meeting with a Health Coach and a report to each member who completes the process. Employees who complete the 3-step program will not have a health assessment fee (HAFEE). Please retain a copy of your Health Action Plan. It will serve as verification of participation in the event of a discrepancy. Employees/spouses completing the 3-step process can participate in the Healthy Rewards Program and be eligible for a \$250 Health Reimbursement Account.

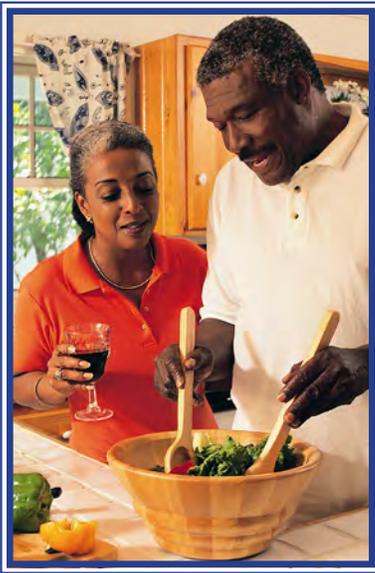
Additional services and classes are available through Workforce Health. Topics include: Diabetes, Nutrition, Physical Activity, and Tobacco Education. Representatives from Workforce Health will be at the City of Milwaukee Open Enrollment Fairs and the Wellness Center located in the Zeidler Municipal Building.

Anyone retiring before 12/31/2015 will not be effected by the 2016 health assessment fee (HAFEE).



City of Milwaukee Monthly Health Assessment Fees

<ul style="list-style-type: none"> • Health Assessments (HA) are offered at no cost to all City of Milwaukee employees and spouses. • The entire process for the health assessment includes: lab work, online health questionnaire, health assessment session and tobacco education (if applicable). • City of Milwaukee health insurance participants who do not complete the entire process in the allotted time will pay a health assessment fee (see fees to the right). • Join 90% of your fellow employees in avoiding health assessment fees and improving your health by choosing to fully participate. 	Single (Monthly)	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">\$30.00</td> <td>Did not complete entire HA process</td> </tr> <tr> <td>\$10.00</td> <td>Completed HA, positive for tobacco use (did not complete tobacco education)</td> </tr> <tr> <td>No Fee</td> <td>Completed HA, no tobacco use OR positive for tobacco use (completed tobacco education)</td> </tr> </table>	\$30.00	Did not complete entire HA process	\$10.00	Completed HA, positive for tobacco use (did not complete tobacco education)	No Fee	Completed HA, no tobacco use OR positive for tobacco use (completed tobacco education)				
	\$30.00	Did not complete entire HA process										
	\$10.00	Completed HA, positive for tobacco use (did not complete tobacco education)										
	No Fee	Completed HA, no tobacco use OR positive for tobacco use (completed tobacco education)										
	Family: 1 Employee (Monthly)	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">\$40.00</td> <td>Did not complete entire HA process</td> </tr> <tr> <td>\$20.00</td> <td>Completed HA, positive for tobacco use (did not complete tobacco education)</td> </tr> <tr> <td>No Fee</td> <td>Completed HA, no tobacco use OR positive for tobacco use (completed tobacco education)</td> </tr> </table>	\$40.00	Did not complete entire HA process	\$20.00	Completed HA, positive for tobacco use (did not complete tobacco education)	No Fee	Completed HA, no tobacco use OR positive for tobacco use (completed tobacco education)				
	\$40.00	Did not complete entire HA process										
	\$20.00	Completed HA, positive for tobacco use (did not complete tobacco education)										
	No Fee	Completed HA, no tobacco use OR positive for tobacco use (completed tobacco education)										
	Family: Employee + Spouse (Monthly)	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">\$60.00</td> <td>Did not complete entire HA process</td> </tr> <tr> <td>\$40.00</td> <td>1 person completed HA, 1 did not</td> </tr> <tr> <td>\$20.00</td> <td>2 persons completed HA, 2 positive for tobacco use (did not complete tobacco education)</td> </tr> <tr> <td>\$20.00</td> <td>2 persons completed HA, 1 positive for tobacco use (did not complete tobacco education)</td> </tr> <tr> <td>No Fee</td> <td>2 persons completed HA, no tobacco use OR both positive for tobacco use (completed tobacco education)</td> </tr> </table>	\$60.00	Did not complete entire HA process	\$40.00	1 person completed HA, 1 did not	\$20.00	2 persons completed HA, 2 positive for tobacco use (did not complete tobacco education)	\$20.00	2 persons completed HA, 1 positive for tobacco use (did not complete tobacco education)	No Fee	2 persons completed HA, no tobacco use OR both positive for tobacco use (completed tobacco education)
	\$60.00	Did not complete entire HA process										
\$40.00	1 person completed HA, 1 did not											
\$20.00	2 persons completed HA, 2 positive for tobacco use (did not complete tobacco education)											
\$20.00	2 persons completed HA, 1 positive for tobacco use (did not complete tobacco education)											
No Fee	2 persons completed HA, no tobacco use OR both positive for tobacco use (completed tobacco education)											



Your chance to save. Your chance to choose. Your chance is now.



We are privileged to once again deliver the City of Milwaukee's wellness program to you. Please look for important details in your Launch Kit that was mailed at the end of July as well as the DER web site. Both explain the program and the benefits associated with participation. Make the decision to eat right, stay active and take care of you. Choose to participate in the annual health assessment for savings, but most of all choose to participate for your overall health. We are proud to bring wellness to work for the City of Milwaukee.

Workforce Health works with progressive area organizations who want to make employee health a key business initiative. They recognize the wellness of their workforce as an economic imperative and partner with us to improve the health of their employees. Our programs and services are customized to meet the needs of both employers and employees. Based on the company's aggregate health assessment data, we are able to create an overall company health profile. We'll work with the company to design a wellness plan that best fits their employees' needs and resources to improve health.



workforcehealth.org

Wellness Your Choice Milwaukee

Phase 2: Healthy Rewards

Do you want the opportunity to earn a \$250 Health Reimbursement Account (HRA) to offset your out-of-pocket health care expenses?

If you complete the 2015 3-step Health Appraisal process, you are automatically eligible for Phase 2, the Healthy Rewards program. If you think you might be unable to meet a standard for a reward under this program, you may qualify for an opportunity to earn the same reward by different means. Contact Workforce Health at 414-777-3410 and we will work with you.

Healthy Rewards 2016

The program
runs from
July 1, 2015
until June 30, 2016

There is no sign up process for this program, you can start earning additional points right away! Here's how you get started:

1. Earn Points From Biometrics: Key biometric results from your 3-step Health Appraisal process will be used to award you points. If you are in the optimal category for each measure or have improved a category since your 2014 Health Appraisal, you earn 10 points per measure. The measures are:

- Blood Pressure (*Recheck available at the Wellness Center*)
- Waist Circumference (*Recheck available at the Wellness Center*)
- Fasting Blood Glucose (*Recheck available at the Workplace Clinic*)
- LDL (*Recheck available at the Workplace Clinic*)
- Nicotine and Cotinine (*10 points if negative in 2015; 20 points if you tested positive in 2014 and negative in 2015*)

A minimum of 20 points must come from this section. If you earn less than 40 points for this section, you must complete a 15-minute coaching session. There's no need to submit paperwork for your lab work, we will do all of the calculations and award your points automatically! Check your point total beginning February 1, 2016.

2. Earn Points From Activities: Refer to the chart on the next page to learn how you can earn activity points. All activities must take place between July 1, 2015 and June 30, 2016. **Points can be submitted starting February 1, 2016.** More details to follow.

3. Reach 100 Points, Collect Award: When you reach 100 points, \$250 will be added to your Health Reimbursement Account. Unused monies roll over year to year as long as you maintain employment with the City of Milwaukee, or for 3 years after employment ends. **BONUS:** Your spouse or domestic partner is also eligible for Healthy Rewards, provided they also complete the 3-Step Health Appraisal. This means your family could earn \$500 to offset health care expenses.

Questions? E-mail cityofmke@froedtert.com or call 414-777-3410.



Healthy Rewards Point Opportunities

Earn 100 points total to earn a \$250 HRA

Biometric Point Opportunities- A minimum of 20 points must come from this section!

Blood Pressure	Optimal category or improve a category from 2014 to 2015. <i>Eligible for recheck at the Wellness Center after February 1, 2016.</i>	10 points Maximum: 10 points
Waist Circumference	Optimal category or improve a category from 2014 to 2015. <i>Eligible for recheck at the Wellness Center after February 1, 2016.</i>	10 points Maximum: 10 points
Fasting Blood Glucose	Optimal category or improve a category from 2014 to 2015. <i>Eligible for recheck at the Workplace Clinic after February 1, 2016. Appointment required.</i>	10 points Maximum: 10 points
LDL	Optimal category or improve a category from 2014 to 2015. <i>Eligible for recheck at the Workplace Clinic after February 1, 2016. Appointment required.</i>	10 points Maximum: 10 points
Nicotine and Cotinine	Negative test for 10 points. Negative in 2014 after positive in 2013 for 20 points.	10 or 20 points Maximum: 20 points

Category ranges can be found on the [DER website](#).

Potential biometric points: 60

Activity Point Opportunities

15-Minute Coaching or Nutrition Session	Meet with a Workforce Health coach or registered dietitian to discuss your health goals. May be done in person or telephonically. One session is required if you earn less than 40 biometric points. Schedule at www.pickatime.com/com/healthyrewards	10 points each Maximum: 30 points
Annual Dental Exam	Show a copy of your explanation of benefits or a paid bill.	10 points Maximum: 10 points
Preventative/Wellness Exam	Show a copy of your explanation of benefits or a paid bill.	10 points each Maximum: 20 points
Primary Care Physician Release	Your full lab results will be sent to your PCP.	10 points Maximum: 10 points
Blood Pressure Checks	Complete five blood pressure checks at the Wellness Center.	5 points Maximum: 5 points
Annual Flu Shot	Show a copy of your explanation of benefits, a paid bill or sign a release when WFH provides the shots in fall 2015.	5 points Maximum: 5 points
UHC mobile app or MyUHC.com sign up	Show a copy of your new or existing welcome page for proof.	5 points Maximum: 5 points
Group or Department Programs	Please visit the DER website for more info and a schedule of programs.	Varies Maximum: 30 points
Lunch 'N Learns	See the DER website for a schedule.	Attend 2, receive 5 points Maximum: 15 points
Market Box or Consumer Supported Agriculture Sign Up	Show a copy of a paid bill. To enroll, visit www.growingpower.org , www.farmfreshatlas.org or www.urbanecologycenter.org . Visit the Wellness Center for more information.	5 points each Maximum: 5 points
Physical Activity (no self-report)	Submit proof for 4 weeks in a row of physical activity: <ul style="list-style-type: none"> 10,000 step average per day (for 5 days per week) <u>or</u> 150 minutes of activity per week for biking, swimming, running or walking <u>or</u> 8 classes or general visits at an athletic club or combination Submit proof of an organized athletic event (walk, run, triathlon, etc.).	5 points each Maximum: 30 points

Potential activity points: 165

CITY OF MILWAUKEE DENTAL PLAN COMPARISON CHART

NOTE: These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts.

	CAREPLUS PREPAID IN-NETWORK	DENTALBLUE (WI DentalCare) Standard IN-NETWORK	METLIFE DENTAL PLAN ⁶ IN-NETWORK AND OUT OF NETWORK		
			Police	Fire	General
ANNUAL MAXIMUM	Unlimited	Unlimited	\$1,000	\$1,000	\$1,000
DEDUCTIBLE Single Family	None None	None None	\$25 \$75	\$25 \$75	\$25 \$75
DIAGNOSTIC (Ded waived) Oral Exam, X-Rays	Covered	Covered	You Pay 20%	You Pay 20%	(deductible waived) Covered ^{1,9}
PREVENTIVE Cleaning Fluoride (2x/yr) Sealants (2x/yr)	Covered Covered-age 18 ² Covered-age 15 ²	Covered Covered-age 15 ²	You Pay 20% Covered-age 18 ² Covered-age 24	You Pay 20% Covered-age 18 ² Covered-age 24	Covered ^{1,9} Covered-age 18 ² Covered-age 24
RESTORATIVE Fillings³ Crowns⁴	Covered Covered ⁴	Covered Covered ⁵	You Pay 20% You Pay 20%	You Pay 20% You Pay 20%	You Pay 20% You Pay 20%
PROSTHODONTICS Bridges, Dentures Implants	Covered ⁴ Not Covered	Covered ⁵ Not Covered	You Pay 20% You Pay 20%	You Pay 20% You Pay 20%	You Pay 20% You Pay 20%
PROSTHETICS Denture Repairs	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
ORAL SURGERY⁶ Simple Extractions	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
ENDODONTICS Root Canals	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
PERIODONTICS⁶ Treatment of Gums & Tissue	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
ORTHODONTICS: Example Based on \$5000 Treatment Plan.					
Maximum Plan will pay Employee Co payment⁷	None 50% of \$5000 up to \$750	None 50% of \$5000 up to \$750	60% up to \$2,000 40% of treatment plan charges of \$3,333 or less, up to \$1,333. 100% of the portion of charges exceeding \$3,333.	60% up to \$1,000 40% of treatment plan charges of \$1,666 or less, up to \$666. 100% of the portion of charges exceeding \$3,333.	50% up to \$1,200 50% of treatment plan charges of \$2,400 or less, up to \$1,200. 100% of the portion of charges exceeding \$3,333.
Deductible Dependent Age Limit Invisalign Braces	None None Not Covered	None None Not Covered	None 26 ⁸ Covered	None 26 ⁸ Covered	None 26 ⁸ Covered
Expected co-pay on \$5,000 Treatment Plan:	You Pay \$750	You Pay \$750	You pay \$3,000	You pay \$4,000	You pay \$3,800

NOTES:

1. Covered at 100% of "maximum plan allowance" or the total dollar amount allowed for each dental procedure code.
2. Coverage may extend beyond age limit indicated if part of a Periodontal Treatment Plan.
3. White composite on posterior teeth may be subject to co-payments and/or covered at a lesser percentage than indicated.
4. Covered with base or noble metal. High noble metal is extra.
5. Only base metal covered. Noble or high noble metal and related lab fees are subject to co-payments. Many dentists only use noble metals. Ask your provider to document your out-of-pocket expense prior to initiating treatment.

6. Does not duplicate medical coverage.
7. A new co-payment will be assessed should you change dental plans during orthodontic treatment. Care+plus may reduce the required co-payment for transferring ortho-in-treatment patients based on treatment previously received and remaining length of treatment.
8. Employee and spouse are not subject to age limit indicated.
9. MetLife (General City) – Diagnostic and Preventive will not count against the annual maximum or deductible.

CarePlus has five clinics in the Milwaukee area. You do not need to specify a clinic preference when enrolling and may use the clinics interchangeably. To visit the CarePlus website, navigate to: www.careplusdentalplans.com. Clinics are located at:

1135 S. Cesar Chavez Drive
11711 W. Burleigh Street
6855 S. 27th Street
205 E. Wisconsin Avenue
220 E. Pleasant Street

DentalBlue clinics are located throughout the metropolitan area. You **must** select a clinic from the Anthem Dentacare Standard Provider Directory and indicate a 12 digit clinic/center number during enrollment. DentaCare Directory available on our website, navigate to: www.milwaukee.gov/der/benefits2016. Choose your provider thoughtfully. **DentalBlue does not allow clinic changes outside of open enrollment and will not pay for treatment rendered at a clinic other than the one you select.** Family members are required to use the same clinic although they may see different dentists within the clinic.

To visit DentalBlue’s website, navigate to: www.anthem.com (Select “WI” and “DentalBlue-Dentacare Standard Network” then designate your search parameter.)

MetLife covers the dentist of your choice. You do not need to select a clinic or provider as part of enrollment, and may switch dentists at will. Family members can utilize different clinics and clinicians. By choosing a MetLife participating provider you will not be “balanced billed” for amounts that exceed your co-pay.

***Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist’s actual charge (the ‘Actual Charge’), (2) the dentist’s usual charge for the same or similar services (the ‘Usual Charge’) or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the ‘Customary Charge’). Services must be necessary in terms of generally accepted dental standards.**

To access more information or find a participating general dentist or specialist, visit MetLife’s website www.metlife.com/dental. Enter zip code and select plan type “PDP Plus”.

MetLife PDP Savings* Examples

You may see any dentist – in-network or out-of-network -- with the MetLife dental plan. These hypothetical examples illustrate how receiving services from a PDP (in-network) dentist can save you money and get more services for the \$1000 annual maximum. Both examples assume any applicable deductibles have been met prior to these services being rendered. The R&C Fee refers to “reasonable and customary fees” that MetLife will use as a maximum for that specific service with non-network providers, and the “Dentist’s Usual Fee” refers to an amount higher than either the PDP fee or the R&C fee that a non-network dentist may charge.

Your out-of-pocket costs are usually lower when you visit network dentists. That’s because they have agreed to accept negotiated fees that are typically 15 to 45% less than average dental charges in the same community. This may help lower your final costs and stretch your plan maximum. Negotiated fees may even extend to non-covered services and services provided after you've reached the plan maximum.

METLIFE DENTAL

Example 1 - Your Dentist says you need a Crown —

- PDP Fee: \$375.00
- R&C Fee: \$500.00
- Dentist's Usual Fee: \$600.00

IN-NETWORK When you receive care from a participating PDP dentist:		OUT-OF-NETWORK When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	\$600.00	Dentist's Usual Fee is:	\$600.00
The PDP Fee is:	\$375.00	The R&C Fee is:	\$500.00
Your Plan Pays:		Your Plan Pays:	
80% X \$375 PDP Fee:	- \$300.00	80% X \$500 R&C Fee:	- \$400.00
Your Out-of-Pocket Cost:	\$75.00	Your Out-of-Pocket Cost:	\$200.00

In this example, you save \$125.00 (\$200.00 minus \$75.00)... by using a participating PDP dentist.

Example 2 - Your Dentist says you need a Filling —

- PDP Fee: \$100.00
- R&C Fee: \$125.00
- Dentist's Usual Fee: \$150.00

N-NETWORK When you receive care from a participating PDP dentist:		OUT-OF-NETWORK When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	\$150.00	Dentist's Usual Fee is:	\$150.00
The PDP Fee is:	\$100.00	The R&C Fee is:	\$125.00
Your Plan Pays:		Your Plan Pays:	
80% X \$100 PDP Fee:	- \$80.00	80% X \$125 R&C Fee:	- \$100.00
Your Out-of-Pocket Cost:	\$20.00	Your Out-of-Pocket Cost:	\$50.00

In this example you save \$30.00 (\$50.00 minus \$20.00)... by using a participating PDP dentist.

* Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered. Negotiated fees on non-covered services may not apply in all states.

Flexible Choices Program

Special Note to City of Milwaukee Employees and Spouses about INCREASING YOUR TAKE-HOME PAY

YOU MUST ENROLL EACH PLAN YEAR

**All FSA funds must be used within the Calendar year.
The final filing date for 2016 expenses for Medical, Dependent Care and Parking is
February 15, 2017.**

The *Flexible Choices Program* for out-of-pocket medical, dependent care and the parking benefit expenses will continue during 2016 with *eflex A TASC Division as the administrator*. The *Flexible Choices Program* allows you to **increase your take-home pay**.

There are three separate parts to the City of Milwaukee's *Flexible Choices Program*. If you want to participate in any of the 3 parts, **you must enroll each plan year**. These plans do not automatically renew. For those employees who are not currently enrolled, we urge you to read through the material, call *eflexgroup* if you have any questions or visit them at one of the open enrollment fairs.

If you choose to participate in the program, it does not change your health benefits. It only affects the way that you pay your out-of-pocket medical, your childcare/dependent care, and the work-related parking expenses. Your contribution is taken out of each paycheck before taxes and placed into a tax-free account until you have a qualified expense. Because you would incur these expenses anyway, this is a way you can **lower your income taxes** at **NO** additional cost. Your tax-free payroll deductions for these expenses can save you money in income tax savings depending on your income and tax situation.

1. **Out-of-Pocket Medical Expenses: Annual maximum of \$2,550**

Your contribution to this account should be based upon your expected out-of-pocket medical costs. For example, the following types of expenses would qualify:

- Expenses not paid by your medical plan for prescription; Over the counter medications will be covered if a prescription is obtained through your medical provider;
- Cost of glasses or contact lenses;
- Annual plan deductibles & co-pays for persons in the City's Health Plans;
- Dental co-insurance or co-pays not covered by insurance to name a few.

2. **Childcare/Dependent Care Expenses: Annual maximum of \$5,000 (depends on filing status)**

In order to decide you must balance the tax savings from this benefit versus the tax credit on your personal income tax return. Your contribution to this account should be based upon your expected childcare expenses for your dependent(s) that is **12 or younger**. Your contribution is capped at \$5,000 per year for one or more children or \$2,500 if filing separately.

3. **Parking Benefit Plan Expenses: Annual maximum of \$2,000**

Any work-related parking expenses an employee incurs near his/her workplace or near the location from which an employee commutes to work by mass transit or vanpool. Employees that are reimbursed for parking expenses are not eligible for FSA-Parking Benefits. **Parking money is never lost!** New employees have up to 30 days to enroll after their City Start Date. **Enrollment can be done through the Self-Service program.** As with all things, there are some stipulations for you to consider before making your election decision. Here are the plan's limitations:

- ✓ **The amount you elect to deduct cannot be changed or revoked at will.** Election changes are permitted if you experience a qualified change in status. Detailed explanations of the qualified changes are given in the IRS regulations available through *eflexgroup* Online Internet site.
- ✓ **Overestimated out-of-pocket medical expenses cannot be refunded at the end of the plan year** and up to \$500 will roll over to the next plan year. It pays to be confident about the amount of out-of-pocket medical expenses you expect to incur.

ROLLOVER INFORMATION

Don't let the fear of losing money prevent you from taking advantage of the much more powerful benefits of participating in this plan. City of Milwaukee elected the Rollover Option. **The plan year for expenses incurred is 01/01/2016 until 12/31/2016 with the exception of up to \$500 of your unused Funds for Medical expense account ONLY. These funds can be rolled over and used for the entire year of 2017.**

The percentage of income saved on taxes usually greatly exceeds the minimal year-end account balances, if there are any at all. Take time now to decide how you can reduce your taxable income while saving tax-free for expenses you are going to incur for the new plan year.

For information on **IRS Regulation Changes** for the Plan Year Beginning in 2016, please check the *eflexgroup* web site at www.eflexgroup.com. The site also has copies of IRS Publication 502 for Medical Expenses and IRS Publication 503 for Child and Dependent Care Accounts. *Eflexgroup* claim forms can be printed from the same web site.

Highlights of the City of Milwaukee Flexible Choices Program

- ◆ **Daily Claims Reimbursement:** Checks are prepared and mailed to participants' homes, or direct deposit, or participants also have the option of a debit card to use for payment of their expenses.
 - Debit Card Usage** – The Debit Card allows you to use the money you have in your account without having to wait for reimbursement. **PLEASE SAVE YOUR DETAILED RECEIPTS!! DOCUMENTATION IS REQUIRED to verify your debit card usage.**
- ◆ **Internet submission of claims:** Conveniently submit your claims online at www.eflexgroup.com.
- ◆ **24 hours a day, 7-days-a-week access** to information about account status claims received and reimbursement check issues. By simply logging into www.eflexgroup.com or by using touch-tone phone participants can access up-to-date information regarding their accounts.
- ◆ If you are already enrolled, remember **you must re-enroll each year for Flexible Choices.**
- ◆ For more information about the City of Milwaukee's Flexible Choices Program, call *eflexgroup* at **1-877-933-3539 (7:00 am – 7:00 pm CST)** or contact **City of Milwaukee at 414-286-3184.**

See the Health Insurance Benefit Summary Tables of the 2016 Open Enrollment Booklet for changes to deductibles and co-pays. If you haven't participated in Flexible Choices in the past, you may want to consider the implications of these changes on your out-of-pocket medical expenses for 2016.

Employees leaving City employment (resignation, discharges, and retirement) must submit reimbursement request to Eflexgroup within 30 days of separation. No exceptions!

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that group health plans (including the City of Milwaukee Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, a covered employee’s spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including: open enrollment and special enrollment rights. Specific information describing continuation coverage can be obtained from the Department of Employee Relations, Employee Benefits, 200 East Wells, Milwaukee, WI 53202, 414-286-2047, attention: Crystal Owens.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the City of Milwaukee Employee Benefits of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the City of Milwaukee Employee Benefits of that fact within 60 days of the SSA’s determination and before the end of the first 18 months of continuation coverage. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the City of Milwaukee Employee Benefits of that fact within 30 days of SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee’s enrolling in Medicare, or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. You must notify the City of Milwaukee Employee Benefits within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee’s spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in

another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the City of Milwaukee Employee Benefits to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

City of Milwaukee Employee Benefits
200 East Wells Street, Room 706
Milwaukee, WI 53202

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

City of Milwaukee Employee Benefits
200 East Wells Street, Room 706
Milwaukee, WI 53202

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days (or enter longer period permitted by Plan) to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visits the EBSA web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

LONG TERM DISABILITY OVERVIEW

The City of Milwaukee provides Long Term Disability (LTD) insurance through Lincoln Financial Group. All eligible General City employees (excludes Sworn Fire and Police) who have been on the payroll for 6 months will receive this benefit.

When a covered disability keeps you out of work, Long Term Disability Insurance helps keep your finances protected. The plan pays 60% pre-disability earnings while you recover. Your benefits continue for the policy's benefit period or until you are no longer disabled, whichever comes first, and help provide you and your loved ones security when you need it most.

The Long Term Disability Insurance Program features two parts:

- a. Basic Benefit (Plan 1) – is provided by the City at no cost to eligible City of Milwaukee employees. This plan has a 180 calendar day waiting period.
- b. Buy-Up Plan (Plan 2) – eligible general city employees can enroll in 60, 90 & 120 calendar day waiting period. There's a cost to the employee. The cost will be deducted from your paycheck. The buy-up ends when the basic plan becomes payable.

Who is eligible for Long Term Disability Insurance – General City employees that are full-time and work **over 20** hours per week.

If you have additional questions, please contact Crystal Owens at (414-286-2047) or refer to our website www.milwaukee.gov/der/benefits2016.

LIFE INSURANCE OVERVIEW

GROUP LIFE INSURANCE

This overview only affects General City, Wisconsin Center District, HACM and RACM employees. This does **not** apply to sworn Fire, Police, MPS, MATC, MMSD, and Veolia employees.

All eligible employees working more than 20 hours per week automatically receive a \$50,000 basic life insurance policy that is paid for by the City of Milwaukee. Enrollment in basic life insurance is automatic and employees are not required to sign up or complete enrollment forms to participate in this plan.

THE \$50,000 CITY PAID GROUP LIFE INSURANCE IS ONLY APPLICABLE TO ACTIVE EMPLOYEES.

Eligible employees also have the option to purchase voluntary life insurance and family life insurance coverage.

****IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE PLANNING ON RETIREMENT**

RETIREEES CANNOT INCREASE THEIR LIFE INSURANCE COVERAGE. LIFE INSURANCE COVERAGE FOR RETIREEES IS CAPPED AT THE AMOUNT OF VOLUNTARY LIFE INSURANCE IN EFFECT AT THE TIME OF RETIREMENT. RETIREEES HAVE THE OPTION TO ELECT A LOWER AMOUNT OF COVERAGE.

If you are not currently enrolled in voluntary life insurance and you intend to retire and would like to carry group life insurance while retired, you **MUST** elect at least 50% of your annual base salary in voluntary life insurance coverage during open enrollment (October 19 through November 6, 2015).

IF YOU ARE NOT ENROLLED IN AT LEAST 50% OF VOLUNTARY LIFE INSURANCE AT THE TIME OF RETIREMENT YOU WILL NOT HAVE COVERAGE AS A RETIREE.

If you currently *do not* have voluntary life insurance and are enrolling for the first time, evidence of insurability will be required.

ANY ELECTION OF VOLUNTARY LIFE INSURANCE THAT REQUIRES EVIDENCE OF INSURABILITY (EOI) WILL BECOME EFFECTIVE ON THE 1ST OF THE MONTH FOLLOWING THE DATE APPROVED BY THE CARRIER. COVERAGE WILL NOT BECOME EFFECTIVE UNTIL THE 1ST OF THE MONTH FOLLOWING THE APPROVAL DATE.

PLEASE NOTE: YOU MUST PHYSICALLY BE AT WORK FOR AT LEAST ONE (1) DAY WITH THE NEW VOLUNTARY COVERAGE PERCENTAGE IN EFFECT TO BE ELIGIBLE TO ELECT THAT NEW COVERAGE PERCENTAGE AS A RETIREE.

VOLUNTARY LIFE INSURANCE

Voluntary life insurance is coverage that an employee can purchase in addition to the \$50,000 City paid coverage. Eligible employees may purchase voluntary life insurance coverage in the following options:

- 50% of annual base salary
- 100% of annual base salary
- 150% of annual base salary
- 200% of annual base salary
- 250% of annual base salary
- 300% of annual base salary

The most voluntary coverage any employee can have is 300% of their salary, not to exceed \$300,000.

To calculate the amount of voluntary coverage that you would like to carry, take your annual base salary and multiply it by the selected % above and then round up to the nearest thousand.

Example: Annual Salary \$38,450.00 x 50% = \$19,225.00 rounded up to \$20,000.00.

Cost of Voluntary Life Insurance

Voluntary life insurance is entirely paid for by the employee based on the following age-banded rates:

<u>Age</u>	<u>Rate per \$1,000</u>
Under 25	\$0.05
25-29	\$0.06
30-34	\$0.08
35-39	\$0.09
40-44	\$0.10
45-49	\$0.15
50-54	\$0.23
55-59	\$0.43
60-64	\$0.66
65-69	\$1.27
70-74	\$2.06
75-79	\$2.43
80-84	\$2.80
85-89	\$5.29
90 +	\$8.00

Example: \$20,000 ÷ 1,000 (rate per \$1,000) = 20 x .05 (age 23) = \$1.00 per month.

Deductions occur monthly and are displayed on the second paycheck of each month.

Increases of greater than 50% of existing voluntary life insurance will require evidence of insurability (proof of good health). You will be notified by the Aetna Life Insurance Company if this is required. If you currently are not enrolled in voluntary life insurance and are enrolling for the first time, evidence of insurability is required for all percentages of coverage.

Employees may only cancel voluntary life insurance during open enrollment periods.

FAMILY LIFE INSURANCE

All eligible employees may elect family life insurance. To be eligible an employee must carry voluntary life insurance. Family life insurance is a single fixed deduction that covers the employee's family (spouses, domestic partners and dependent children) regardless of the number of dependents. Spouses and domestic partners will have \$25,000 of coverage. Dependent children 6 months of age through 26 years of age will have \$10,000 of coverage and dependent children 14 days old through 5 months of age will have \$2,000 in coverage. Employees may elect family coverage within 30 days of a qualifying event (marriage and births).

If you are enrolling in family life insurance for the first time during open enrollment, evidence of insurability (proof of good health) will be required for a spouse/domestic partner. You will be notified by the Aetna Life Insurance Company if this is required.

Employees may only cancel family life insurance during open enrollment periods. The employee is the only beneficiary of family life insurance. Family life insurance terminates upon the death or retirement of the employee. If an employee resigns or is terminated they can port their family coverage.

Cost of Family Life Insurance

Family life insurance will be paid for by the employee based on a flat rate of \$5.25 per month.

Special Notice to all City Employees, Retirees and their Families

Women's Health and Cancer Right Act Notice Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of mastectomy.

The City of Milwaukee health plans comply with these requirements. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The City of Milwaukee health plans do not impose penalties (for example, reducing or limiting reimbursements) and do not provide incentives to induce attending providers to provide care inconsistent with these requirements.

Questions, call the Employee Benefits Office at (414) 286-3184.



City of Milwaukee



Workplace Clinic

Convenient, on-site health care services at no cost.

Location:

841 N. Broadway, Milwaukee, WI 53202 (Zeidler Municipal Building)

Enter through the Market St. entrance on the corner of Kilbourn Ave. and Market St.

Clinic Schedule and Appointments:

Monday	7 a.m. - 3 p.m.
Tuesday	7 a.m. - 3 p.m.
Wednesday	10:30 a.m. - 6:30 p.m.
Friday	8 a.m. - 2 p.m.

To make an appointment, please call **414-777-3410**.

ID Required:

If you and your spouse/partner are covered under the City's healthcare insurance, bring your UHC insurance card just like you would to any other appointment. If you and your spouse/partner are not covered under the City's healthcare insurance, please bring your employee ID or your spouse/partner's ID number along with your health insurance card.

Cost:

The clinic is FREE for all City of Milwaukee employees, their spouses and domestic partners. You do not need to have health insurance through the City.

Treatment Services:

- Sore throats
- Sinus infections
- Bronchitis
- Ear infections
- Pink eye
- Flu/cold symptoms
- Minor rashes
- Urinary tract infections
- Sprains and strains



Be insured to *smile more.*



With our affordable dental plans you can have a smile, and an investment, to feel good about. CarePlus Dental Plans mean you and your family will always have access to high-quality dental care. Worrying about the out-of-pocket expense is a thing of the past. CarePlus is available at each of the convenient Dental Associates centers.

Call **800.318.7007** or visit **CarePlusDentalPlans.com** and learn more about CarePlus and *smiles made easy.*

Dental Associates, the exclusive provider to CarePlus, has 7 convenient Southeastern Wisconsin locations:

Franklin

6855 S. 27th St.
Franklin, WI 53132
414.435.0787
866.824.3220

Milwaukee - Beerline B

220 E. Pleasant Street
Milwaukee, WI 53212
414.435.5850
844.852.2371

Milwaukee - South

1135 S. Cesar Chavez Dr.
Milwaukee, WI 53204
414.645.4540
866.346.8098

Wauwatosa

11711 W. Burleigh St.
Wauwatosa, WI 53222
414.771.2345
800.398.0687

Kenosha

7117 Green Bay Rd.
Kenosha, WI 53142
262.942.7000
866.811.4619

Milwaukee - Downtown

205 E. Wisconsin Ave.
Milwaukee, WI 53202
414.778.3600
877.398.2638

Sturtevant

10155 Washington Ave.
Sturtevant, WI 53177
262.884.3011
877.251.0240

For more Dental Associates locations, visit **DentalAssociates.com**.

Care-Plus Dental Plans, Inc. is a non-profit Limited Service Health Organization licensed and regulated by the State of Wisconsin Office of the Commissioner of Insurance. Dental Associates is the exclusive provider to Care-Plus Dental Plans, Inc.

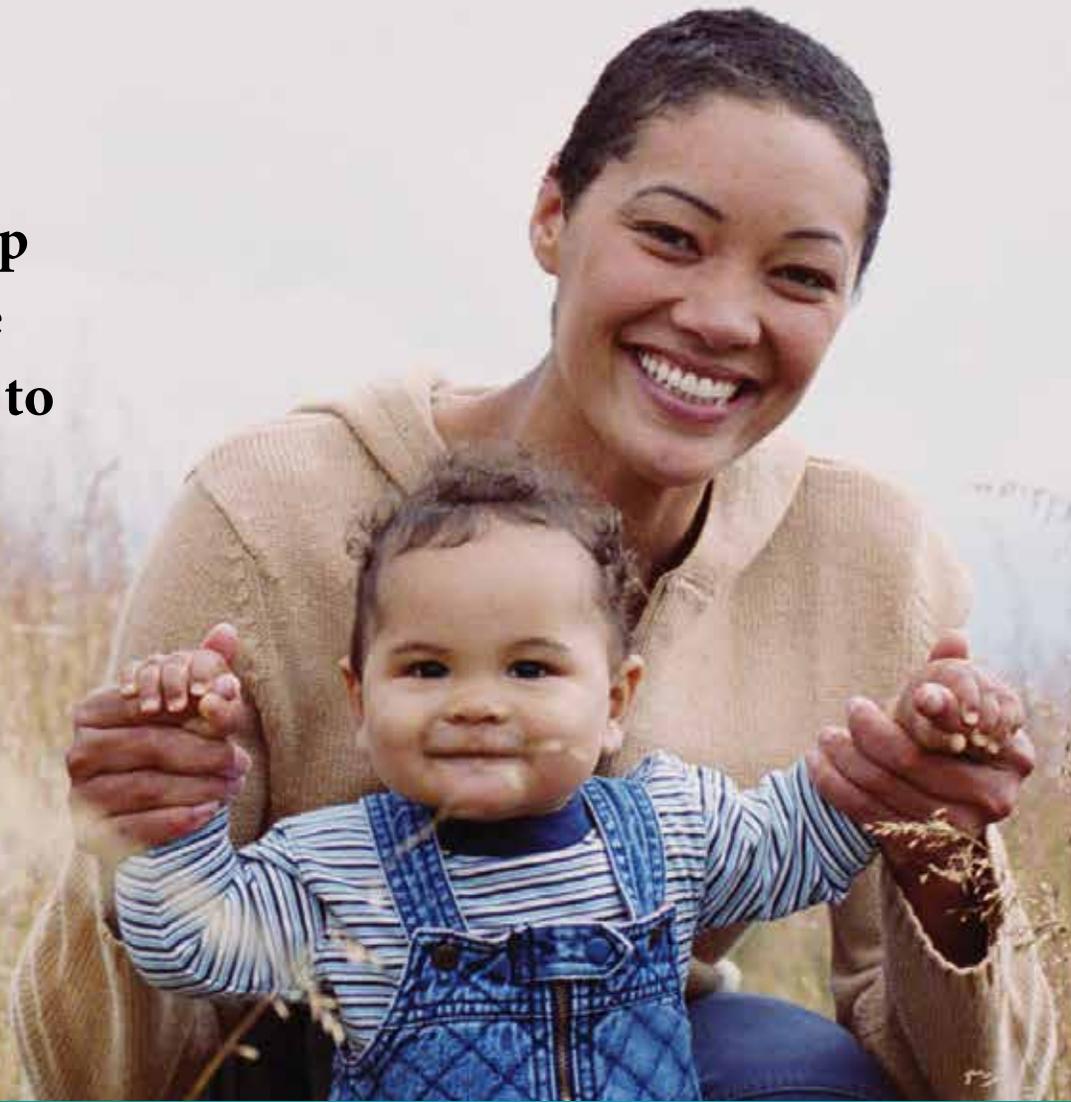
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CarePlus

A healthy smile could mean better health — that's why I need a good dental plan.

Regular visits to the dentist can be important to your overall health. MetLife's dental benefits plan can help you get the protection you need while making it easier and more affordable to see your dentist regularly.

Now that's something to smile about.



Freedom of choice to go to any dentist.
Additional savings* when you visit a network dentist.
Educational tools and resources to help you make better choices.
Service where and when you want it.



MetLife

**For more information and tools, visit MetLife's Oral Health Library,
accessible from the MetLife Dental Center at www.metlife.com/dental.**

*Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details

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**One Plan.
Lots of Choices.
Perfect Smiles.**

Choosing your dentist is an important decision. That's why Dental Blue® gives you access to one of the largest dental networks statewide. More dentists. More locations.

Dental Blue – giving employees something to smile about.

For more information, call 866-589-0582 or visit anthem.com.

Anthem  

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City of Milwaukee Employee Assistance Program



What Does The EAP Help With?

- Alcohol/Drugs
- Domestic Violence
- Mood/Anxiety Concerns
- Family Issues
- Financial Difficulties
- Interpersonal Problems
- Legal Problems
- Marital/Couple Difficulties
- Stress Management

◇ *Contact the EAP for more information.*



Scan Me!

What is The Employee Assistance Program (EAP)?

The employee assistance program, or EAP, is a brief counseling, assessment and referral service for employees and their family who may be experiencing personal or work place problems. Everyone has problems from time to time. Usually, we work them out. But sometimes problems persist, becoming serious enough to affect us both off and on the job.

At such times, an EAP may be able to help.

It is your program to utilize when you and your family members need help. If you know a co-worker is having problems, remind them of the program. If you have questions or comments, feel free to call for a confidential consultation.

We have answers to your health questions.

You have access to a wide range of health and well-being information — seven days a week, 24 hours a day

Whenever you have a question, you can speak with registered nurses and master's-level counselors who can help with a variety of problems, ranging from medical and family matters to personal, legal, financial and emotional needs. One toll-free phone number gives you access to experienced professionals, including:

- Registered nurses
- Master's-level counselors
- Legal and financial professionals
- Community resources

When you call, a registered nurse or a master's-level counselor can discuss topics with you including:

- Choosing appropriate medical care
- Self-care information
- Minor illnesses and injuries
- Childhood illnesses
- Medication safety
- Information on medications
- Help finding a doctor
- Relationship worries
- Stress and anxiety
- Coping with grief and loss
- Personal, legal and financial issues
- General health information

When you call the same toll-free number, you can listen to audio messages on more than 1,100 health and well-being topics. To listen to your message of choice, press * to speak with a nurse who will provide you with

information on the health topics along with the three-digit access pin number. More than 600 audio messages are recorded and available in Spanish, along with multilingual translation services, and service for callers with hearing impairments.

Expanded support

If face-to-face resources are appropriate for your situation, a representative can refer you to local, in-person support. Counselors also can refer you to a wide range of national and community resources.

We also can help you find a doctor or specialist, and check to see if a doctor is in your network and available. We may even be able to make the appointment for you.

24-hour convenience

Nurses and counselors help you and your family identify and address concerns that span the spectrum of work and life.

Current health and well-being information

Nurses and counselors offer service based on up-to-date medical and professional guidelines. We consistently deliver this valuable service, so you can be confident that you and your family receive reliable health, personal, legal and financial information you can use every day.

Nurses or counselors are available 24 hours a day, seven days a week.

Care24®



For more information, call:
1-800-942-4746

myuhc.com

TTY callers, please call 711 and ask for the number above.

This program is not a substitute for a doctor's or professional's care. This service should not be used for emergency or urgent care situations. In an emergency, call 911 or go to the nearest emergency room. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

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Money, security, recovery

When a covered disability keeps you out of work, long-term disability insurance helps keep your finances protected.

The plan pays a portion of your income while you recover. And your benefits continue for the policy's benefit period or until you are no longer disabled, whichever comes first—helping provide you and your loved ones security when you need it most.

Conditions that could lead to a long-term disability claim include:

• Surgery

• Injury

• Illness

• Accident

• How does long-term disability coverage work?

Mike signed up for long-term disability insurance when he became a full-time employee several years ago. Two months ago, he was injured in a traffic accident that resulted in a covered disability. His policy has an elimination period of 90 days. If he is disabled after that time, he is eligible to begin collecting benefits. The policy provides a maximum benefit of 50% of pay, up to \$5,000 a month, and a maximum benefit duration of five years.

Mike paid for his insurance with after-tax dollars, so his benefits are tax-free.*

If Mike's disability prevents him from working for 10 months, here are the benefits he could collect:

Sample LTD benefit payment

Mike's monthly pay	\$3,500
Mike's maximum monthly benefit	× 50%
Mike's monthly benefit	= \$1,750
Mike's approved benefit duration	× 7
Mike's total long-term disability benefit	= \$12,250

Mike's policy includes a 90-day elimination period, so his benefit duration is seven months.

*If the cost of Mike's coverage is paid pretax, he will pay tax on the benefits he receives during his disability.



Your employer pays you while you're working.



Lincoln pays you while you're recovering.



You and your loved ones



Your bills and expenses



• Two forms of income protection

If you have short-term disability coverage, do you need a long-term policy? The answer is yes. Sixty-five percent of working Americans couldn't cover living expenses for a year, according to the Council for Disability Awareness (March 2010).

• You decide how to use your benefits

You can spend your benefits on anything you want or need: food, car payments, utilities or even a night out at the movies.

• More benefits of your insurance

Survivor Income Benefit. A lump sum is paid to your beneficiaries if you die while on disability.

Waiver of Premium. You don't have to pay premiums during periods of approved disability under our policy.

• How much coverage do you need?

Long-term disability insurance pays benefits for up to a specific period of time or until you are no longer disabled—because your expenses don't stop while you aren't working:

- Food
- Car payments and maintenance
- Utilities
- Mortgage or rent

Long-term disability income insurance can help protect your hard-earned savings so you can focus on your recovery.

• Protect your paycheck

There are some important advantages to buying insurance that's offered to employees as a group.

Cost	This coverage is offered at group rates, which are often less expensive than rates for individual policies.
Convenience	Payroll deduction is simple and easy.
Confidence	You can choose the right coverage at work.

• We help you get back to work

EmployeeConnectSM services. You have access to counselors and other assistance for personal, legal, financial and other issues.

Progressive Partial Disability Benefit. If you're only able to do part of your job or work part time, you can receive partial benefits. With part-time earnings and a partial disability benefit, you could receive up to 100% of your predisability earnings.

Get cash when you need it most with LTD insurance from Lincoln Financial.



457 can supplement your pension and help you have a more comfortable retirement.

What is 457?

A 457 deferred compensation plan is a supplemental retirement-savings program that offers a tax-advantaged way to invest for potentially more retirement income. Pre-tax contributions and any earnings are taxed as ordinary income when withdrawn.*

Why join a 457 plan?

By investing through your employer's 457 deferred comp plan, you may be able to fill a potential gap between what your pension provides and income you may need. Consider this: a 65-year-old couple retiring this year may need \$220,000 (in today's dollars) to cover medical expenses throughout retirement.¹

How do you put money in your account?

That's the easiest part! Your contributions are automatically deducted before taxes from your pay, contributed to your 457 plan account, and then invested as you direct.*

Deferred comp is designed for long-term investing. However, if you leave employment with your 457 plan sponsor, you can withdraw money without paying a 10% penalty. Consider that, if you're thinking about early retirement.

What about the risks of investing?

Investing involves market risk, including possible loss of principal. But you also face several other risks. While your Nationwide Retirement Specialist cannot offer investment, tax or legal advice, we'll help you put the various risks into perspective and explain strategies that may help you deal with them.

How do I get started in a 457 plan?

Contact your Nationwide Retirement Specialist:

Amber Peters or Charmaine Martin
414-276-2079
www.Milwaukee457.com

Retirement Specialists are registered representatives of Nationwide Investment Services Corporation, member FINRA.

**Note: If your employer's 457 plan offers and you take advantage of a Roth option, your contributions are taken after taxes are applied, but withdrawals of contributions and their potential earnings would be tax-free (subject to certain conditions).*

Sources: ¹Source: Fidelity Benefits Consulting, 2014.

The Nationwide Group Retirement Series includes unregistered group fixed and variable annuities and trust programs. The unregistered group fixed and variable annuities are issued by Nationwide Life Insurance Company. Trust programs and trust services are offered by Nationwide Trust Company, FSB, a division of Nationwide Bank. Nationwide Investment Services Corporation, member FINRA. Nationwide Mutual Insurance Company and Affiliated Companies, Home Office: Columbus, OH 43215-2220.



TO DO LIST & REMINDERS

- ✓ **Health and/or Dental Benefits – All employees must re-enroll in health insurance for 2016! Re-enrollment is not required for dental insurance.**
- ✓ **If You Are Adding A Dependent** – Please remember to complete the entire “Life Event” process by enrolling them in health and/or dental benefits. You are required to submit verification of dependent eligibility (marriage certificate, birth certificate). Please send a copy to Employee Benefits Division, 200 East Wells Street, Room 706, email a copy to vbrook@milwaukee.gov or fax it to (414) 286-2106.
- ✓ **Divorces** – Employees are required to report divorces within 30 days of the divorce. Ex-spouses will have health and/or dental benefits through the end of the month of the divorce. Failure to report divorces within 30 days may effect employee premiums and Cobra eligibility.
- ✓ **Return to Work** – Employees returning to work from layoff or leave of absence are required to submit health, dental and FSA enrollment forms. Employees returning to work from layoff and were enrolled in the **LTD Buy-up** must **re-enroll**.
- ✓ **Long Term Disability** – Eligible employees are automatically enrolled in the **Basic (Core)** LTD with 180 day waiting period. All eligible employees can enroll in the **LTD Buy-up** when first hired after the completion of a 6-month waiting period or during open enrollment. You can only **waive** the LTD Buy-up during open enrollment.
- ✓ **Flexible Choice Program** – You must enroll or re-enroll each plan year. Re-enrollment is not automatic. ***Dependent Care is for childcare expenses for your dependent(s) that are 12 years old or younger.**
- ✓ **Deductions** – Health and dental deductions are taken the 1st and 2nd paychecks of the month. Commuter Value Pass (CVP) deductions are taken the 1st paycheck of the month. Group Life Insurance (Voluntary & Family Life) deductions are taken the 2nd paycheck of the month. Long Term Disability (Buy Up), Flexible Spending Account (Medical, Dependent Care & Parking) and Pension deductions are taken each paycheck of the month.
- ✓ **Beneficiaries** – Please remember to update your Life Insurance, Deferred Compensation and Pension Beneficiaries when one of the following occurs; birth, divorce or death.

How To Enroll

SELF-SERVICE PROGRAM

- 1) The login Internet address is milwaukee.gov/selfservice which is on the left side. In order to access the Self-Service Program, all Active employees must have their Employee ID Number and a Password. You will need the Employee ID/User ID Number and a Password in order to access the web browser either from home or work. To request or reset a Password, visit www.milwaukee.gov/rits .
 - a) The Employee ID Number which is a six-digit number and you can find this number on your payroll statement at the top of the middle column above the Department's name.
- 2) If you add an dependent(s):
 - a) All eligible dependent names must be **capitalized**.
 - b) We require a copy of the **Birth Certificate, Marriage Certificate and Social Security Number for all eligible dependents**.
- 3) If you remove a dependent(s):
 - a) You must complete a health and/or dental enrollment form.
 - b) Remember, you can remove a dependent at any time. You can't add a dependent at anytime.
- 4) If you do not want health or dental coverage, the "WAIVER FORM" is available to download at www.Milwaukee.gov/der/benefits2016. The waiver form must be sent to the Department of Employee Relations, City Hall, Room 706. There is no penalty for an employee who waives coverage and takes coverage through a spouse or another health plan.

Active Employees Making a Health/Dental Plan Change for the Year 2016

All active employee Self-Service enrollment elections must be submitted by 10:59 p.m. on **Friday, November 6, 2015**.

Self-Service Instructions

City of Milwaukee Human Resources Management System Employee Self Service Program

All Active employees will use the Self Service program to change your Health, Dental, Flexible Choices, Long Term Disability and Life Insurance benefits:

Login on the Internet to: milwaukee.gov/selfservice

Log into the Self Service Program

1. Enter your User ID your Password. If you do not remember your password **and have not set up the “forget your password”** option, please go to: www.milwaukee.gov/rits to request or reset a password (**please do not call the Employee Benefits Division**).
2. Click the Sign In button. If this is your first time logging into the Self Service program, please set up the “Forget your password” option. Click Save. You are now set up to have a new password e-mailed to you when you “forget your password.”

Health Insurance

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the Health Plan Option.
3. Click the Circle button to select a Health Plan.
4. If you have dependent(s) on your plan or would like to add a dependent, continue and scroll down to the Enroll Your Dependents (Add/Review Dependents). **All dependent names must be capitalized and check the student box.** The Social Security Number (SSN) for all dependents will be required.
5. Click the Store button for the additional options. The store button will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options, for example any changes to the dental insurance or flexible choices program.
6. If there are no additional changes, then click the **SUBMIT** button.
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

Dental Insurance

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the Dental Plan Option.
3. Click the Circle button to select a Dental Plan.
4. If you have dependent(s) on your plan or would like to add a dependent, continue and scroll down to the Enroll Your Dependents (Add/Review Dependents). **All dependent names must be capitalized.** The SSN for all dependents will be required.
5. Click the Store button for the additional options. The store button will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to

store the elections. Do not click the submit button until you have completed all of your options.

6. If there are no additional changes, then click the **SUBMIT** button
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

Flexible Choices Programs

If you wish to participate in any of the three parts of the Flexible Choices Program for 2016, you must enroll each plan year. These plans do not automatically renew.

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select Flexible Choices Medical, Dependent Care or Parking Expenses.
3. Click the Circle button to select a Flexible Choices Option or click No, I do not want to enroll.
4. Submit the annual pledge amount for each of the Flexible Choices option you want to be enrolled in 2016.
5. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
6. If there are no additional changes, then click the **SUBMIT** button.
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

Long Term Disability

If you wish to select a Long Term Disability (LTD) buy down of 60, 90,120 day coverage, or change the current buy down selection.

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the LTD Buy Down.
3. Click the Circle button to select the LTD buy down coverage.
4. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
5. If there are no additional changes, then click the **SUBMIT** button.
6. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

View Your Direct Deposit Stubs

1. Login on the internet to: milwaukee.gov/selfservice
2. Enter your User ID (Employee ID) and password.
3. Click on Self-Service/Payroll and Compensation/View Paycheck or Payslips.

Life Insurance

If you wish to enroll or change the Voluntary Life Insurance enrollment.

Path: Main Menu/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click OK
3. Click the Edit button to select the Voluntary Group Life Option.
4. Click the Circle button to select Voluntary Group Life Plan.

5. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the **Store** button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
6. If there are no additional changes, then click the **SUBMIT** button
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

If you wish to enroll in Family Life Insurance.

Path: Main Menu/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click OK.
3. Click the Edit button to select the Family Life option.
4. Click the Circle button to select the Family Life plan.
5. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the Store button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
6. If there are no additional changes, then click the SUBMIT button.
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

Entering Life Insurance Beneficiaries

Path: Main Menu/Self Service/Benefits/Benefits Summary

1. Under Type of Benefit click Life
2. Click the Edit button at the bottom of the screen.
3. Click Add a New Beneficiary if you wish to add someone new to the list.
4. Complete the required fields for Personal Information.
5. Complete the required fields for Status Information
6. If the address of the beneficiary is different from your own address click to uncheck the box under Address and Telephone next to Same Address as Employee.
7. After you uncheck the Same Address as Employee box an Edit Address button will appear. Click the Edit Address button.
8. Complete the Edit Address information and click OK.
9. Review the address information. If it is correct click Save.
10. Click OK.
11. Click Return to Change Current Beneficiaries and Allocations (this link is located at the bottom of the page).
12. Click the box to the left of the beneficiary name that you want to keep as a primary or secondary allocation. Add a percentage for this beneficiary under either the New Primary Allocation column or the New Secondary Allocation column. (Do not put in % signs.)

Note: Existing names may display on this page. These names are health insurance dependents that were carried over. If you want them to be a life insurance beneficiary you must click the box to the left of the name and add a percentage.

13. Click Update Totals. Note: totals must equal 100.
14. Click Save.
15. Click OK (Note: totals will not appear on this screen).

16. Click Return to Life Insurance Main (this link is located at the bottom of the page).
17. Click Return to Employee Benefit Summary.
18. Click Life – your updated beneficiaries and percentages will now display. This will complete your life insurance beneficiary elections.

View Your W-2/W-2C forms

1. **Path to Consent:** Main Menu>Self Service>Payroll and Compensation>W-2/W-2C Consent (You only need to consent once).
2. To view W-2/W-2C form (after consenting you may view the form electronically when it becomes available): **Path:** Main Menu>Self Service>Payroll and Compensation>View W-2/W-2C Forms.
3. To view prior tax year W-2/W-2C Form click the “View a different tax year” button.
4. Employees will have access to self-service for 1 year after separation from City Service. Prior to separation, be sure your primary e-mail address is changed from your City e-mail address to a private address (i.e., yahoo, gmail, hotmail, etc.).

For COBRA Enrollees **You must re-enroll in a Health Plan for 2016.**

In the **JOB TITLE** box of all enrollment forms:

1. A COBRA enrollee will write "COBRA" in the JOB TITLE box.
2. **DO NOT** write anything in the CITY START DATE and RETURN TO WORK DATE boxes.



BENEFIT PLAN DEFINITIONS

Deductible – This is the amount you are required to pay each year before the plan begins to pay benefits. You begin accumulating expenses toward the satisfaction of your deductible at the beginning of each benefit year.

Co-Insurance – This is the percentage of the cost you pay when you receive certain health care services. For **UHC Choice Plan**, you pay 10% or 30% up to \$750 single and \$1500 family. For **in-network** with **UHC Choice Plus Plan**, you pay 10% or 30% up to \$1500 single and \$3000 family.

Co-payment – This is the flat dollar amount you pay when you receive certain medical care services. Co-pays may be due at the time you receive the service. Example: Emergency Room co-pays are \$200 per visit.

In-Network – This is care or services provided by doctors, hospitals, labs or other facilities that participate in the network of providers assembled by your UnitedHealthCare. Generally, you pay less when you receive care in-network because the providers agree to charge a pre-negotiated, lower fee. This reduces your out-of-pocket costs and the overall claim cost.

Out-of-Network – This is care or services furnished by doctors, hospitals, labs or other facilities that do not participate in the UnitedHealthCare's provider network. If you are enrolled in the Choice Plus Plan and use an out-of-network provider, your share of the cost is based on the reasonable and customary charges allowed by the plan. Amounts charged over the reasonable and customary do not count towards the annual deductibles and out-of-pocket maximums.

Out-of-Pocket Maximum – When you meet the annual out-of-pocket maximum, the plan will pay the full cost of covered expenses for the remainder of the benefit year. Covered expenses (deductibles and co-insurance amounts) apply towards the out-of-pocket maximum.

UnitedHealth Premium Tier 1 – Members in City of Milwaukee health plans pay lower co-insurance amounts (10%) for services provided by UnitedHealth Premium Tier 1 Physicians. UnitedHealth Premium Tier 1 Physicians receive the premium designation for:

*Quality & Cost Efficiency (For quality, care providers must meet national industry standards of care. For cost-efficiency, care providers must meet local market benchmarks for the cost-efficient use of resources in delivering care).

TELEPHONE NUMBERS & WEBSITES

Employee Benefits Division	414-286-3184	www.milwaukee.gov/der/benefits2016
<u>Health Plans</u>		
United Healthcare Choice Plus Plan	1-800-841-4901*	www.myuhc.com
United Healthcare Choice Plan	1-800-841-4901*	www.myuhc.com
UHC Care 24	1-800-942-4746	
<u>Pharmacy</u>		
OptumRx	1-800-841-4901	www.myuhc.com
<u>Dental Plans</u>		
MetLife	1-800-942-0854	www.metlife.com/dental
Care Plus Dental	414-771-1711	www.careplusdentalplans.com
DentalBlue	1-866-589-0582	www.Anthem.com
Lincoln Financial Group (LTD)	1-800-423-2765	www.lincoln4benefits.com
Eflex/TASC (Flexible Choice Program)	1-877-933-3539	www.eflexgroup.com
Nationwide Retirement Solutions (Deferred Compensation)	1-800-829-1183	www.milwaukee457.com
Aetna (Life Insurance)	1-800-523-5065	

***Be sure to use the phone number on the back of your UnitedHealthcare ID card.**

If you have any questions regarding your benefits, or regarding unpaid bills, or problems with service, please call your health or dental plan. **DO NOT** call Employee Benefits until you have contacted your health or dental plan and are unable to arrive at a resolution. Employee Benefits will attempt to assist you to resolve your problem, but in no case will Employee Benefits attempt to change, question or provide a medical opinion. Remember to document all your conversations with dates, times and names. We will ask you for this information when you call our office.

NOTES