2017

OPEN ENROLLMENT BOOKLET

The Year 2017 RETIREE Open Enrollment Period Runs From OCTOBER 17, 2016 through NOVEMBER 4, 2016

City of Milwaukee

Retirees

Employes' Retirement System

789 North Water Street
Suite 300
Milwaukee, WI 53202
(414) 286-3557
www.cmers.com

MILWAUKEE

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DISCLAIMER:

Receiving this booklet does not necessarily imply you are eligible for City health 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 retiree 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 plans.

September, 2016

Dear City of Milwaukee Retiree Members:

There are no benefit design changes in 2017 for Medicare retirees or retirees under 65 without Medicare. There will be a decrease of approximately -2.9% in the premiums for Medicare retirees based on the utilization and experience of medical and prescription drug services, as well as cost trends for both. Retirees under 65 without Medicare will have an increase in their premiums of approximately 8.5% based on the utilization, experience and cost trends of that group.

The City will continue to offer both the UHC Choice and UHC Choice Plus plans in 2017. Those under 65 without Medicare generally find the UHC Choice plan to be a better value. Members with Medicare generally find the UHC Choice Plus plan to be a better value, if they select a City plan rather than a Milwaukee Retiree Association (MRA) Medicare Advantage plan.

The MRA continues to offer Medicare Advantage (MA-PD) plans that provide an outstanding value to Medicare retirees. These Medicare Advantage plans are comprehensive plans with benefits different than the City-sponsored Medicare supplement type plans. The enhanced ($10 monthly plan premium) UnitedHealthcare Group Medicare Advantage (PPO) Plan or the Humana Group Medicare Advantage (PPO) Plan are offered by MRA in cooperation with National Benefit Consultants, Inc. (NBC). Over 1,200 Medicare retirees are currently enrolled in these plans and have been for over ten years. Look for additional information from MRA and NBC to be mailed to your homes. For more information about the group Medicare Advantage plans, contact National Benefit Consultants, Inc. at 1-800-875-1505.

Medicare eligible members using the City's Medicare supplement type plans will continue to have their prescriptions filled through UHC Medicare Part D drug plan. Medicare members will have a 20% co-insurance with a cap of $75 per month or $150 for a three month supply. Medicare members can get a three month supply at retail pharmacies or through home delivery with UHC Medicare Part D.

Retiree members without Medicare (generally under 65) will continue to have prescriptions filled by OptumRx. They will have a 20% co-insurance with a $4 minimum and a $75 cap for a single month, or will be able to get a three month supply through mail order with OptumRx with a cap of $150.

If you are currently enrolled in a City Medicare supplement plan, either UHC Choice or UHC Choice Plus and you decide not to remain in these plans as of January 1, 2017, you **must** notify the Employes' Retirement System (ERS) in writing by Friday, November 4, 2016. City sponsored cancellation forms (and enrollment forms) can be found on the ERS website www.cmers.com/library/forms. Assistance for requested plan changes will be provided at the Open Enrollment meetings as well.

If you are a City of Milwaukee Medicare retiree, talk to fellow retirees, the MRA and National Benefit Consultants regarding your options. You are welcome to attend the City's Open Enrollment Fairs to consider and determine the most appropriate healthcare plan option for your situation. The ERS, DER, UHC, OptumRx, and National Benefit Consultants will be available to answer your questions during the Open Enrollment Fairs and through the phone numbers listed in the back of this book.

Sincerely,
Renee Joos
Employee Benefits Director

Retiree Open Enrollment

General Information

The Annual RETIREE Open Enrollment will take place from

October 17, 2016 through November 4, 2016

This booklet includes information for all City of Milwaukee Members.

- Some information is specific for **Medicare members**, some for **non-Medicare members**.
- Some information is specific for members enrolled in **UHC CHOICE PLUS** and some information is specific for members enrolled in **UHC CHOICE**.
- There is also information about the City's selection of the **UnitedHealthcare MedicareRx for Medicare members**.
- **Non-Medicare members** will be enrolled in **OptumRx.**

We hope the information is helpful to you in making critical decisions regarding your health plan choices as a City of Milwaukee retiree. This is your only opportunity during the calendar year to make a change to your health plan for 2017.

Remember, if you have questions regarding retiree benefits; please contact ERS at (414) 286-3557.

In 2017 the City is providing the following health plans for Retirees:

- **UnitedHealthCare (UHC) Choice Plus, a comprehensive PPO plan that allows you to use any provider. This offers the best value for Medicare members (see page 8).**
- **UnitedHealthCare (UHC) Choice, a comprehensive EPO plan with a national network of providers. This offers the best value for non-Medicare members (under 65).**
- Medicare members also have the choice of two additional plans including a low premium plan sponsored by Milwaukee Retiree Association (MRA).
- **IF YOU ARE NOT MAKING A CHANGE YOU DO NOT NEED TO DO ANYTHING**.
- If you change your enrollment between UHC Choice and UHC Choice Plus you will need to complete a health enrollment form.
- If you are a Medicare member and leave the City plan and take one of the Milwaukee Retiree Association (MRA) plans you will need to notify the ERS staff in writing.
- All Medicare members should use their prescription drug card from UnitedHealthcare MedicareRx.
- Non-Medicare retirees will continue to use the UnitedHealthcare card for both health and prescription benefits.

Be sure to contact your health plan or doctor's office to make sure your doctors and preferred hospital are continuing to accept the plan you select for 2017. All retiree enrollment forms **must be in the ERS office on or before 4:30 pm Friday, November 4, 2016.**

Open Enrollment Fairs

The City will hold seven (7) Open Enrollment Fairs that are open to all City employees and retirees. The schedule is listed below.

Tuesday, October 18th - 1:00 p.m. to 4:00 p.m. ..... Fire and Police Academy
..... 6680 North Teutonia Avenue

Thursday, October 20th - 9:00 a.m. to 1:00 p.m. ..... City Hall Rotunda
..... 200 East Wells Street

Tuesday, October 25th- 1:00 p.m. to 4:30 p.m. ..... DPW Field Headquarters
..... 3850 North 35th Street

Wednesday, October 26th – 1:30 p.m. to 5:30 p.m. ……Wilson Park Senior Center
…… 2601 West Howard Avenue

Thursday, October 27th - 2:00 p.m. to 5:00 p.m. ..... Tippecanoe Public Library
..... 3912 South Howell Avenue

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

Thursday, November 3rd – 9:00 a.m. to 1:00 p.m..... City Hall Rotunda
..... 200 East Wells Street

When this booklet was printed the City had not established Health/Dental terms for the year 2017 with all employee groups. As a result the employee and retiree contribution levels for active and newly retired may be affected.

City of Milwaukee UnitedHealthcare CHOICE:

The UHC Choice Plan is administered by UnitedHealthcare. Their phone number is 1-800-841-4901.

- UHC CHOICE provides uniform City benefits through **in-network** providers.
- UHC CHOICE has a national network that in 2017 has over 650,000 physicians and health care professionals and over 5,000 hospitals throughout the United States.
- A retiree outside of SE WI can enroll in UHC CHOICE in 2017 and use any UHC providers and hospitals outside of SE WI.
- Members enrolling in UHC CHOICE in 2017 **DO NOT** need to select a primary care physician (PCP).
- If your provider leaves UHC CHOICE before the end of the plan year, you must see a new provider offered by UHC CHOICE or pay the provider expense out-of-pocket. The City cannot guarantee that a provider will be with UHC Choice Plan for the entire year. Physician contracts are established throughout the year, so any physician may choose not to continue with the contract at the renewal date.
- **All emergency services are covered as "in-network", with in-network deductible and co-insurance.**
- **All preventive services, as defined by UHC and coded by your physician are covered at 100% without any deductible or co-insurance.**

You will be able to go to any UnitedHealthcare network provider in the United States. Be sure to check that the doctor and hospital you want are in the UHC CHOICE Plan network before you finalize your selection. You can do this by calling UnitedHealthcare at 1-800-841-4901, or by going to the internet at www.uhc.com.

City of Milwaukee UnitedHealthcare CHOICE PLUS:

The UHC Choice **PLUS** is administered by UnitedHealthcare. Their phone number is 1-800-841-4901.

- UHC CHOICE **PLUS** - provides uniform City benefits through both **in-network** and out-of-network providers. There are higher deductibles and co-insurance with the UHC Choice **PLUS** Plan.
- UHC CHOICE **PLUS** - has a national network that in 2017 has over 650,000 physicians and health care professionals and over 5,000 hospitals throughout the United States.
- A member outside SE WI can enroll in the UHC CHOICE **PLUS** Plan in 2017 and use any provider, either in-network or out-of-network.
- Members in UHC CHOICE **PLUS** Plan do not need to select a primary care physician.
- If your provider leaves the UHC network before the end of the year, you can continue to see that provider, but will have to pay the higher deductibles and co-insurance.
- **All emergency services are covered as "in-network", with in-network deductible and co-insurance.**
- **All preventive services, as defined by UHC and coded by your physician are covered at 100% without any deductible or co-insurance.**

NOTICES

Notice for all Duty Disability, Medicare Members, Medicare dependents or Medicare family members to enroll in both Part A and Part B of Medicare:

Both members and spouses eligible for Medicare as a result of a disability, or duty disability and who are under 65 must be enrolled in Medicare Part A and Part B. This is a requirement of all health plans offered by the City. Medicare Part A and Part B provide additional value. It is your responsibility to be properly enrolled in Medicare Part A and Part B when participating in the City of Milwaukee Retiree health plan coverage (or COBRA) when Medicare-eligible due to Social Security disability or at age 65. Coordinate enrollment dates carefully and in advance so you are granted the requested effective date needed. Medicare A and B must be in place when participating on City coverage when Medicare pays Primary (first). It is your responsibility to ensure both Medicare A and B are in place when participation on plan coverage in which Medicare is Primary Payer. If Medicare is not properly in place you will incur claim related issues or a gap in coverage.

Important Reminder: Call or visit your local Social Security Office if you have questions regarding your Medicare Part A and Part B entitlement, eligibility and enrollment. Contact your local Social Security Field Office at 1-800-772-1213. You can also enroll at www.ssa.gov. You can access additional information about Medicare benefits by visiting their website at www.medicare.gov or call 1-800-Medicare.

Notice for all Medicare Members, Medicare dependents or Medicare family members:
All City enrollees with Medicare are automatically enrolled in the UnitedHealth MedicareRx group Part D plan.

No application should ever be mailed directly to the health plan.
See complete instructions on the health enrollment form.

Notice to members Regarding the Thirty-Day Rule:
Retired employees are responsible for keeping their enrollment status current -notifying the Employee Retirement System **within 30 days** of births, adoptions, marriages, divorces, dependents ceasing to be dependents, former dependents that become eligible dependents again, deaths and **Medicare coverage**. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) **There will be no exceptions to this rule.**

Notice to Members regarding the One-Family Plan Rule:
Members who are married to each other may only carry one health plan between them. You are required to report your marriage to another active City employee or retiree within 30 days of your marriage. City of Milwaukee members are eligible to add their domestic partner and domestic partner children to their health benefits.

Notice to Members with Other Health Coverage:
With the exception of Medicare Part A & B, members with other coverage through their own employment, or their spouse's employment or retirement must choose one plan. There is no penalty for a City member who waives coverage and enrolls in coverage through a spouse or another health plan. When a member loses other coverage they can re-enroll with City retiree coverage. If you terminate your City of Milwaukee coverage, you may re-enroll during open enrollment. Coverage will not be effective until January 1st of the following year.

Something to Remember

We strongly recommend that you review the benefits and cost to you of the two plans offered. Call the plans directly for more information, or attend one of the information fairs listed on page 5. Remember, you can also get information from the Milwaukee Retiree Association for the two plans they provide through National Benefit Consultants (800-875-1505), including the "low premium plan".

Remember, if you have questions regarding retiree benefits; please contact Employes' Retirement System (ERS) at (414) 286-3557. Employee Benefits Division does not handle retiree benefits.

Coordination of Benefits between Medicare (Primary) and UHC (Secondary) for Medicare – eligible Retiree Health Plan Participants

How coordination of benefits work, and what does this mean for me as a Medicare member?
This means that on a single bill there may be portions paid by Medicare, portions paid by UHC, and portions paid by the member until the deductibles are reached. The examples below use the UHC Choice PLUS plan. The Federal Medicare program has not determined Medicare Part A and Part B deductibles as of this retiree handbook printing. 2016 Medicare costs are illustrated.

Medicare A (Hospital portion) has an $1,288 (2016) annual deductible, and then Medicare pays at 100%
Medicare B (Major Medical portion) has a $166 annual deductible (2016), and then Medicare pays at 80%
The UHC Choice Plus plan has a $1,500 deductible in 2017, a $1,500 co-insurance at 10%, and then pays at 100% for Medicare eligible expenses. **City members will not have a Choice/Choice Plus co-insurance for any Medicare eligible services.**

Example #1

The first bill you receive is under Medicare Part B (Major Medical portion) and is for $1,500:
Medicare Part B pays $0 on the first $166 of services.
UHC Choice Plus pays $0 on the first $166 of service.
Member pays $166 of the $1,500. Member's Medicare Part B deductible is met.

There is a $1,334 balance before the UHC Choice PLUS $1,500 deductible is reached.
Medicare Part B pays 80% of the $1,334 or $1,067.20.
Member pays $266.80,
UHC Choice $1,500 deductible is met with Medicare paying $1,067.20 and member paying $432.80
Any future Medicare Part B eligible services are paid at 80% by Medicare Part B and 20% by UHC.
Member has no additional costs for Medicare Part B eligible services.
Member has NO CO-INSURANCE for Medicare Part B eligible services.
Total out of pocket cost for member with Medicare Part B bill of $1,500: $432.80

Example #2

The first bill you receive is under Medicare Part A (Hospital) and is for $1,500:
Medicare Part A pays $0 on the first $1,288 of services.
UHC Choice Plus pays $0 on the first $1,500 of services.
Member pays the first $1288 in cost. (Medicare Part A deductible, $1,288, has been met)

There is a $212 balance.
Medicare Part A pays $212 balance (100% of eligible charges over $212)
Member pays $0
UHC Choice Plus deductible, $1500, has been met
Member has no additional cost for Medicare Part A eligible services.
Member has NO COINSURANCE for Medicare Part A eligible services.
Total out of pocket cost for member with Medicare Part A bill: $1,288.

Note: Medical necessity and medical benefits may be different between Medicare and UHC. If services are not eligible for Medicare payments, but are eligible for UHC payments, member may have co-insurance costs of 10% or 30% depending on the provider and the services that are not eligible for Medicare.

BENEFIT PLAN DEFINITIONS

Deductible – 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 – The percentage of the cost you pay when you receive certain health care services. For the **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-Insurance is based on Premium Tier 1 Providers.**

Out-of-Pocket Maximum – The maximum amount you'll pay during the year for covered health care services. 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.

Co-payment – The flat dollar amount you pay when you receive certain medical care services. Co-pays are typically due at the time you receive the service. **Example: Emergency Room co-pays are $200.**

In-Network – 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 – 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.

***UnitedHealth Premium Tier 1 Provider** – Members pay lower co-insurance amounts (10%) for services provided by UnitedHealthcare Premium Tier 1 Physicians. UnitedHealthcare Premium Tier 1 Physicians are evaluated annually and receive the premium designation for providing higher quality care with better patient outcomes at a lower cost. For quality care and cost efficiency measures, providers must meet national industry standards of care and local market benchmarks for the cost-efficient use of resources in delivering care.

If a provider is not evaluated for Premium Tier 1, members will continue to pay a 10% coinsurance.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR:
MEDICARE MEMBERS ONLY

NOTE: Medicare Coordination Strategy: see page 8 for example. The City considers ALL payments made by Medicare as the Primary health insurance payer for participants to be counted as the retiree's contribution to UHC Choice and UHC Choice PLUS deductibles, co-insurance and out-of-pocket maximum(s). The actual out-of-pocket costs for Medicare retirees who only use Medicare services will be lower because of the coordination of benefit strategy. The out of pocket maximum assumes that the Medicare Part A deductible will be $1,288 and Medicare Part B will be $166 in 2017. For benefits that are not covered by Medicare but are covered by UHC Choice or UHC Choice PLUS, services are subject to full deductible, co-insurance and out of pocket.

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

Type of Coverage	UHC CHOICE	UHC CHOICE PLUS (Replaces the Basic Plan)	
	Network Only Benefits	**Network Benefits**	**Non-Network Benefits**
1. Annual Deductible –(Member pays) Individual Deductible	$750 per year (see page 8).	$1,500 per year (see page 8).	$3,000 per year (see page 8).
2. Co-Insurance – (Member pays) Each Member pays:	10% up to $750 (see page 8).	10% up to $1,500 (see page 8).	30% up to $3,000 (see page 8).
3. Out-of-Pocket Maximum – (Member pays) (includes both deductible & co-insurance) **Individual Out-of-Pocket Maximum**	Up to $1,500 per year (see page 8).	Up to $3,000 per year (see page 8).	Up to $6,000 per year (see page 8).
4. Emergency Health Services (Member 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 I Provider.**	70%**after Deductible met. ****Increases to 90% for UHC Premium Tier I Provider.**	70% after Deductible met.
6. Physician Office Services – Sickness & Injury ****Increases to 90% for UHC Premium Tier I Provider.**	70%**after Deductible met. ****Increases to 90% for UHC Premium Tier I Provider.**	70%**after Deductible met. ****Increases to 90% for UHC Premium Tier I Provider.**	70% after Deductible met.
7. Preventive Care Services Include Preventive Care Visit, Lab, or other preventive test. Generally when a service is performed during your preventive care visit and has a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and there are no known symptoms, illness 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 UnitedHealthCare. 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 (Maximum $75). **20% co-insurance (20% of the total cost of a 3 month supply. Maximum $150).**	20% co-insurance (Maximum $75). **20% co-insurance (20% of the total cost of a 3 month supply. Maximum $150).**	Not Covered. Not Covered.
9. Out-of Pocket Maximum for Prescriptions - (Employee Pays)	$3600	$3600	Not Covered.

.SUMMARY OF HEALTH INSURANCE BENEFITS FOR: MEDICARE MEMBERS ONLY

NOTE: Medicare Coordination Strategy: see page 8 for example. The City considers ALL payments made by Medicare as the Primary health insurance payer for participants to be counted as the retiree's contribution to UHC Choice and UHC Choice PLUS deductibles, co-insurance and out-of-pocket maximum(s). The actual out-of-pocket costs for Medicare retirees who only use Medicare services will be lower because of the coordination of benefit strategy. The out of pocket maximum assumes that the Medicare Part A deductible will be $1,288 and Medicare Part B will be $166 in 2017. For benefits that are not covered by Medicare but are covered by UHC Choice or UHC Choice PLUS, services are subject to full deductible, co-insurance and out of pocket.

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

Type of Coverage	UHC CHOICE	UHC CHOICE PLUS (Replaces the Basic 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(except for #29 & #30)	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 (Oral surgery coverage is limited to 13 specific oral surgical procedures. (See end of benefit summary on pg. 12).* **(UHC-Choice members must use in-network providers).**	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 are 50 visits 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: MEDICARE MEMBERS ONLY

NOTE: Medicare Coordination Strategy: see page 8 for example. The City considers All payments made by Medicare as the Primary health insurance payer for participants to be counted as the retiree's contribution to UHC Choice and UHC Choice PLUS deductibles, co-insurance and out-of-pocket maximum(s). The actual out-of-pocket costs for Medicare retirees who only use Medicare services will be lower because of the coordination of benefit strategy. The out of pocket maximum assumes that the Medicare Part A deductible will be $1,288 and Medicare Part B will be $166 in 2017. For benefits that are not covered by Medicare but are covered by UHC Choice or UHC Choice PLUS, services are subject to full deductible, co-insurance and out of pocket.

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

Type of Coverage	UHC CHOICE	UHC CHOICE PLUS (Replaces the Basic 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.	Not Covered.
29. Vision Care **Only one routine vision exam per year with an in-network:**			
Optometrist	90% after Deductible met.	90% after Deductible met.	Not Covered.
Ophthalmologist -Increases to 90% for UHC Premium Tier 1 Provider.**	70%**after Deductible met.	70%** after Deductible met.	Not Covered.
NO ADDITIONAL DISCOUNTS FOR FRAMES OR LENSES. For more information about in-network physicians, visit www.myuhc.com.	****Increases to 90% for UHC Premium Tier 1 Provider.**	****Increases to 90% for UHC Premium Tier 1 Provider.**	
30. Nutritional Counseling			
Dietitian	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
Physician	70%**after Deductible met.	70%**after Deductible met.	70% after Deductible met.
****Increases to 90% for UHC Premium Tier 1 Provider.**	****Increases to 90% for UHC Premium Tier 1 Provider.**	****Increases to 90% for UHC Premium Tier 1 Provider.**	
31. Prosthetic Devices	90% after Deductible met.	90% 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.		

*** UnitedHealthcare and Anthem Oral Surgery are limited to the following 13 oral surgical procedures. UHC-Choice members must use in-network providers (see #14 on page 11):**

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;
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.

.SUMMARY OF HEALTH INSURANCE BENEFITS FOR:
NON-MEDICARE MEMBERS ONLY

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 will prevail.

Type of Coverage	UHC CHOICE	UHC CHOICE PLUS (Replaces the Basic Plan)	
	Network Only Benefits	**Network Benefits**	**Non-Network Benefits**
1. Annual Deductible –(Member 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 –(Member pays) Individual Family	10% up to $750 10% or 30% up to $1500 per family not to exceed $750 per member.	10% up to $1,500 10% or 30% up to $3000 per family not to exceed $1500 per member.	30% up to $3,000 30% up to $6000 per family not to exceed $3000 per member.
3. Out-of-Pocket Maximum for Health (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 (Member 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 Premier 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 Include Preventive Care Visit, Lab, or other preventive test. Generally when a service is performed during your preventive care visit and has a 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 member 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 (minimum $8 & maximum $150.	20% co-insurance (minimum $4 & maximum $75). 20% co-insurance (minimum $8 & maximum $150).	Not Covered. Not Covered.
9. Out-of-Pocket Maximum for Prescriptions – (Member Pays)	$3600	$3600	Not Covered.

.SUMMARY OF HEALTH INSURANCE BENEFITS FOR:
NON-MEDICARE MEMBERS ONLY

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 will prevail.

Type of Coverage	UHC CHOICE	UHC CHOICE PLUS (Replaces the Basic 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 (except for #29 & #30).	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. 15**).	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.	90% 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 max per year for each necessary therapy.	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.

.SUMMARY OF HEALTH INSURANCE BENEFITS FOR:
NON-MEDICARE MEMBERS ONLY

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.

Type of Coverage	UHC CHOICE	UHC CHOICE PLUS (Replaces the Basic Plan)	
	Network Only Benefits	**Network Benefits**	**Non-Network Benefits**
24. Urgent Care	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
25. 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.
26. Substance Use Disorder	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
27. 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.
28. Transplant Services	90% after Deductible met.	90% after Deductible met.	70% after Deductible met.
29. Vision Care **Only one routine vision exam per year with an in-network:** **Optometrist** **Ophthalmologist - **Increases to 90% for UHC Premium Tier 1 Provider.** **NO ADDITIONAL DISCOUNTS FOR FRAMES OR LENSES.** For more information about in-network physicians, visit www.myuhc.com.	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.**	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), adopted children and children placed for adoption as mandated by the State or Federal government. Based on the recent federal health care reform, coverage for dependent children is through the end of the calendar year in which the dependent child or adult child turns 26, without regard to the adult child's school status, marital status or dependent status.		

*** UnitedHealthcare and Anthem Oral Surgery are limited to the following 13 oral surgical procedures. UHC-Choice members must use in-network providers (see #14 on page 14):**

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;
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 Diabetic Benefits for Members

Diabetic Claims (Equipment and Supplies) Claims Adjudication Processes

Non-Medicare Members	
Item	**Claim Adjudication**
Durable Medical Equipment (DME) to include insulin pumps and the supplies used for insulin pumps and meters.	Processed through the medical benefit for both UHC Choice and UHC Choice PLUS plans (See #15 on the Summary Benefit Table). Glucose meters and insulin pumps are covered at 90% co-insurance after satisfying deductible.
Diabetic testing supplies to include test strips, lancets, syringes, etc.	Processed through the pharmacy benefit for both UHC-Choice and UHC-Choice Plus. All members have a 20% co-insurance (minimum $4 and maximum $75) for diabetic testing supplies. 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

Medicare Members	
Item	**Claim Adjudication**
Durable Medical Equipment (DME) to include insulin pumps and the supplies used for insulin pumps and meters.	Processed through the medical benefit for both UHC Choice and UHC Choice PLUS plans (See #15 on the Summary Benefit Table). Glucose meters and Insulin pumps are covered at 90% co-insurance after satisfying deductible.
Diabetic testing supplies to include test strips, lancets, syringes, etc.	Processed through your Medicare Part B coverage. All members will have a 20% co-insurance once an individual reaches their Part B deductible for the plan year. ***(This list can include drugs that are self-administered, drugs used in association with Durable Medical equipment, clotting factors and immune Globulin, and Chemotherapy drugs).**

Special Notice to all

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.

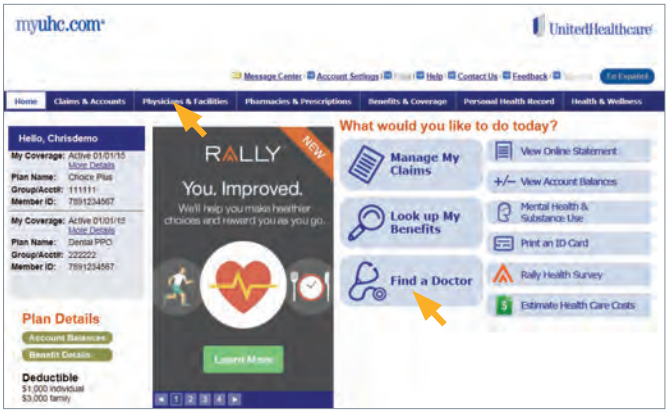
The City of Milwaukee health plans comply with these requirements. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The City of Milwaukee health plans do not impose penalties (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 Employes' Retirement System at (414) 286-3557.

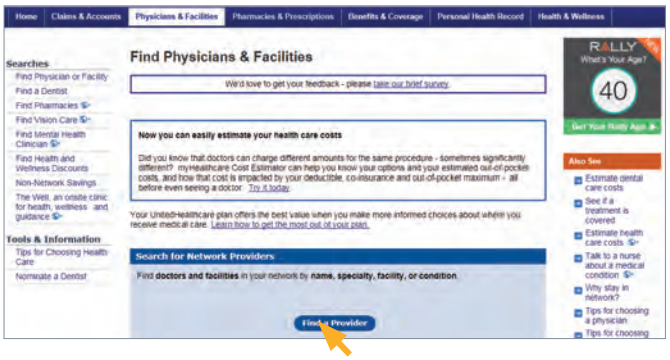
Finding a doctor or hospital on myuhc.com®

Use doctors, hospitals, pharmacies, labs and other providers and facilities in your UnitedHealthcare health plan network to help you save money and lower health care costs.

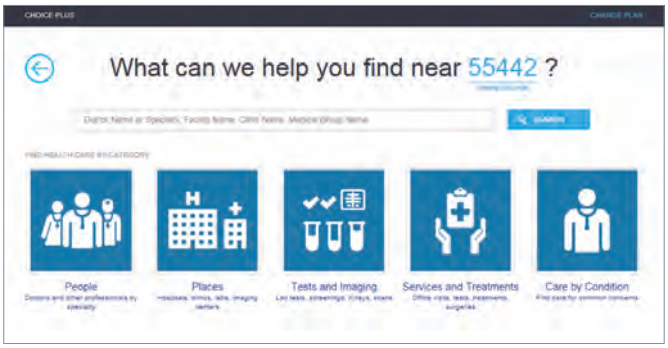
1 Login to **myuhc.com**. You can create an account by clicking on "Register Now".



2 Once logged in, you can click "Find a Doctor", or "Physicians & Facilities" to begin your search.



3 Click on "Find a Provider" to search for a network doctor or facility.



4 Your ZIP code will automatically be used - you can change this by clicking "Change location". Then you have two choices:

- Enter the provider name, facility or medical group in the search box.

OR

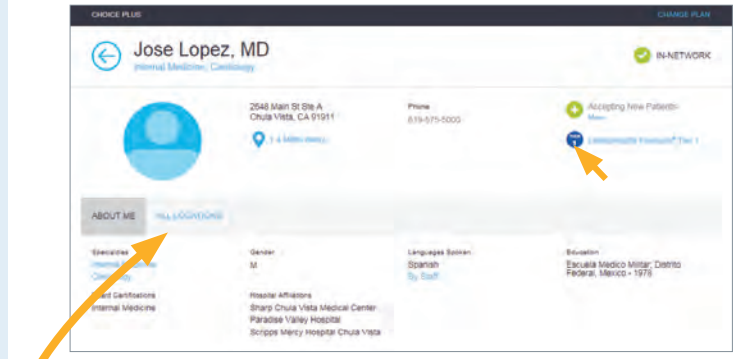
- Click on the icon that reflects the type of provider you are looking for and follow the prompts.

Please note: The following provider search experience is not compatible with Windows Internet Explorer 8 (IE8). If your system is using the IE8 web browser you'll automatically be directed to an earlier version of the UnitedHealthcare provider search tool.

UnitedHealthcare®

5 Choose from Primary or Specialty care, and then select the type of physician.

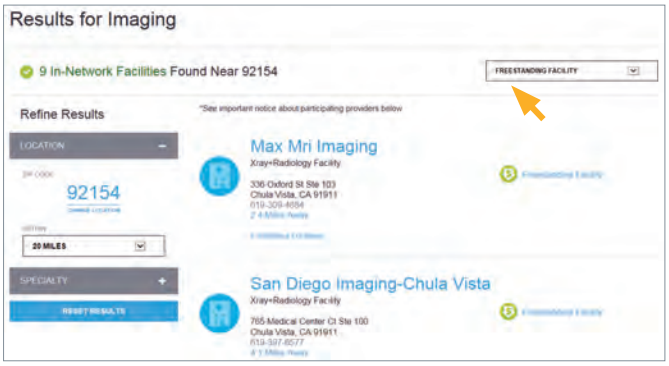
6 A list of doctors in your ZIP code area will be provided under Primary Care Physician.



7 Click the doctor's name to find additional information including address, phone number, if they are accepting new patients, hospital affiliation and if the doctor is a UnitedHealth Premium® Tier 1 provider. Just look for the TIER 1 indicator.

If you need the provider ID# to identify your PCP, you'll find it under "All Locations".

Freestanding Facilities



8 Find a "Freestanding Facility" by clicking "Places" or "Tests & Imaging," when you begin your search. (see the screen shot in step 4)

Call us with any questions.

Find the phone number for customer care on your health plan ID card.

UnitedHealthcare®

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

Only individual physicians that meet UnitedHealth Premium designation criteria, or physicians in designated specialties who are part of medical groups that meet UnitedHealth Premium criteria for group practices and who have sufficient claims data for analysis, may be designated. All physicians that contract with UnitedHealthcare have met credentialing requirements. Regardless of designation, plan enrollees have access to physicians in the UnitedHealthcare network as described in their benefit plan. Specialties for which there are no quality guidelines currently established in the program are excluded from evaluation and are noted as such.

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

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OPTUMRx®

Discover the convenience of OptumRx® Mail Service Member Select℠

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.

OPTUM™ **optumrx.com**

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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OPTUMRx®

Coupons for brand-name medications
Are these really a good deal?

Drug companies are using copay coupons to increase sales of brand-name medications. They offer coupons or other kinds of discounts that lower or eliminate your copay, or cost, for a specific drug.

That seems like a pretty good deal.

So what's the problem?

Drug companies typically offer coupons only on their most expensive medications. While a coupon means you pay less, the total, or true cost of the brand-name medication doesn't change.

Look at the difference in true average cost for a 30-day supply of Lipitor® and its generic version:

Generic Lipitor true cost: $10[1]

Brand Lipitor true cost: $225[1]

Who pays?

- **Your employer**
- **You**

As your employer's costs go up, your cost likely will, too. You could face higher health care premiums, higher copays and coinsurance and possibly reduced access to prescription drug coverage.

Coupons mean much higher costs

Total cost of generic Lipitor: $120 per patient, per year

Total cost of branded Lipitor: $2,700 per patient, per year

2,250% more

Remember:

Many coupons expire after a short trial period. When they do, you may end up paying much more.

Continued

What can I do?

Don't assume that coupons are a good deal. They can cost you in the long run.

Here are a few simple steps you can take to help keep your prescriptions affordable:

Use **generic medications** whenever possible — even if a coupon for the brand is available. Your cost for the generic will likely be similar to your cost for the brand, even with the coupon.

If a generic isn't available, ask your doctor if there is a brand-name medication or a different generic medication that's less expensive.

Be sure to check **myuhc.com®,** where you can find coverage details and lower-cost medication options.

For medications you need to treat an ongoing condition, such as high blood pressure or high cholesterol, you may save by using home delivery.

Questions?

We're here to help you find the lowest-cost options.
Call the number on the back of your plan ID card or visit **myuhc.com®.**

[1]OptumRx external commercial book of business, third quarter of 2015.

OPTUM® **optumrx.com**

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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All City of Milwaukee Medicare Members have the UnitedHealthcare MedicareRx for Groups Part D Prescription Drug Plan. All members in the UHC Choice and UHC Choice PLUS plans have a 20% co-insurance for their drugs.

FAQ – Medicare Members

Why UnitedHealthcare® Medicare Rx?

The **UnitedHealthcare® MedicareRx for Groups (PDP) plan** helps protect you from unexpected changes in your prescription drug costs. Some of the plan highlights include:

- 100% of the drugs on Medicare's Part D drug list are covered.
- More than 65,000 pharmacies in the network including national and regional chain as well as independent neighborhood pharmacies.
- Get convenience and savings delivered to your mailbox when you use OptumRx preferred mail service pharmacy.
- Customer Service available from 8 a.m. – 8 p.m. local time, 7 days a week
- Additional coverage through UnitedHealthcare RxSupplement. The UnitedHealthcare RxSupplement plan provides additional coverage to your Medicare Part D coverage.
- It's easier than ever to take control of your hearing and your health. Health Innovations offers low cost hearing aids.

How do I use my new prescription drug ID card?
Whenever you or a covered family member has a prescription filled at a participating retail pharmacy, present your member ID card to the pharmacist. It displays your member ID number, which your pharmacist needs to process your prescriptions. To quickly find a retail pharmacy near you or to find out if your medication is covered, go to www.UHCRetiree.com or call UnitedHealthcare at 1-866-465-0572, 8:00 am – 8:00 pm, local time 7 days a week.

Why use the UnitedHealthcare pharmacy network?

Save on the cost of generic prescription drugs. Many, but not all, of the pharmacies in UnitedHealthcare's national pharmacy network participate in a special program that could help you save more on your prescription drugs. This program is called the Pharmacy Saver program. With the Pharmacy Saver program, you can fill your prescriptions for as low as $2 at participating pharmacies located in grocery, discount and drug stores where you already shop.

Best of all, Pharmacy Saver is easy. No additional enrollment is necessary. Simply take your qualifying Prescription to a participating pharmacy, show your UnitedHealthcare member ID card and they can help you switch.

What is the difference between a brand-name and generic medication?
Brand-name medications are marketed under a trademark-protected name and are often available from only one manufacturer. Generic medications contain the same active ingredients as the original brand and must meet the same strict federal regulations as their brand-name counterparts for quality, strength, and purity. Generics typically cost less than brands.

Visit **www.UHCRetiree.com** to

Register your account and access online tools:
- Find pharmacies
- Review the plan's drug list
- Print an extra member ID card
- Learn how your plan works by viewing your current plan benefits and coverage
- Search our online health and wellness library
- View claims

Registering is simple and safe, and your information is secure and confidential.

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 **Employes' Retirement System, 789 North Water Street, Suite 300, Milwaukee, WI 53202, 414-286-3557.**

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:
Employes' Retirement System
789 North Water Street, Suite 300,
Milwaukee, WI 53202, 414-286-3557

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:
Employes' Retirement System
789 North Water Street, Suite 300,
Milwaukee, WI 53202, 414-286-3557

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.

HOW TO ENROLL

ENROLLMENT FORMS

1) If you are making a change and need a health enrollment application, they will be available at the following locations:
   a) Open Enrollment Fairs;
   b) Employes' Retirement Service (ERS) website www.cmers.com.
   c) ERS Office, 789 North Water Street, Suite 300.
   d) City Hall, Room 706.
2) If you add or delete a dependent(s):
   a) Complete a Health Enrollment Form,
   b) Write the name of the dependent in SECTION B of the Health Enrollment Form.
   c) Place a check (☑) in the appropriate box in SECTION C on the Health Enrollment Form.
3) **If you do not want health coverage, or wish to waive coverage contact the Health Insurance Specialist at ERS for an appropriate waiver form or send a letter to the pension office with an effective date.** Note there is no penalty for a retiree who waives coverage and takes coverage through a spouse's health plan, other employment or a Medicare complete plan. If you waive coverage you cannot re-enroll until the next open enrollment, unless there is a qualifying event. Retirees must maintain coverage if they wish to re-enroll in a City plan at some future date.
4) **Notice for all Medicare Retirees, Medicare spouses & dependents or Medicare family members to select both Part A and Part B of Medicare**: Retirees eligible for Medicare as a result of a disability and who are under 65 must select Medicare Part A & B. This is a requirement of all health plans.

If you are making a Health Plan Change for the Year 2017

1 . Write **"RETIREE"** in the **JOB TITLE** box of all enrollment forms.
2 . A COBRA enrollee will write "COBRA" in the JOB TITLE box.
3 . DO NOT write anything in the CITY START DATE and RETURN TO WORK DATE boxes.

If you are eligible for both parts of Medicare (Part A and Part B)

1. Please be certain to attach a photocopy of your Medicare I.D. card, and for your spouse if applicable, to your enrollment form.
2. Since coverage under Medicare usually reduces your monthly health insurance premium, it is important you make certain that we know of your Medicare coverage and that we are charging you the correct monthly health insurance premium.

All "RETIREE" applications should be returned to the office at the address below no later than 4:30 p.m. Friday, November 4, 2016:

City of Milwaukee
Employes' Retirement System
Suite 300
789 North Water Street
Milwaukee, WI 53202

Important Telephone Numbers & Websites

ORGANIZATIONS	LOCAL/1-800	WEBSITES
Employes' Retirement System	414-286-3557	www.cmers.com
	1-800-815-8418	
HEALTH PLANS		
UHC Choice	1-800-841-4901	www.myuhc.com
UHC Choice PLUS	1-800-841-4901	www.myuhc.com
UnitedHealthcare Care24	1-800-942-4746	
Medicare	1-800-633-4227	www.medicare.gov
National Benefit Consultants	1-800-875-1505	www.nbci.biz
PHARMACY		
OptumRx (Non-Medicare Member)	1-800-841-4901	www.myuhc.com
UnitedHealthcare MedicareRx	1-866-465-0572	www.uhcretiree.com
LIFE INSURANCE		
MetLife/ERS (Life Insurance)	414-286-6157	www.cmers.com

If you have any questions regarding your benefits, or regarding unpaid bills, or problems with service, please call your health plan. Please **DO NOT** call ERS office until you have contacted your health plan and are unable to arrive at a resolution. ERS will attempt to assist you to resolve your problem, but in no case will ERS 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.