Retiree Benefits Guide 2021

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Introduction

Dear City of Milwaukee Retiree Members:

Welcome to the City of Milwaukee Retiree Benefits Guide. This guide highlights the medical and pharmacy benefits available to City retirees including important information about 2021 open enrollment. In addition, visit the Employes' Retirement System (ERS) website https://www.cmers.com/CMERS_RD/Retirees/Health--Dental-Insurance.htm for more information.

In 2021, based on the utilization and experience of medical and prescription drug services and healthcare cost trends, there will be an increase of 6% in the premiums for non-Medicare retirees under age 65 and a -6% decrease for Medicare retirees.

In addition, **there will be benefit design changes for all retirees enrolled in the City's UnitedHealthcare 2021 health plans**. These include changes outlined below to the deductible, out-of-pocket maximum and the Medicare coordination for Medicare covered members:

EPO Choice Plan

- Increase Deductibles from $1,000/$2,000 Single/Family to $1,500/$3,000
- Increase the Out-of-Pocket Maximum from $2,000/$4,000 Single/Family to $3,000/$6,000

PPO Choice Plus Plan (In-Network)

- Increase Deductibles from $2,000/$4,000 Single/Family to $3,000/$6,000
- Increase the Out-of-Pocket Maximum from $4,000/$8,000 Single/Family to $6,000/$12,000

Medicare Covered Members

- Adjust the coordination style for Medicare members enrolled in the City's health plan so they pay their portion of the benefit design costs for claims covered as secondary under UnitedHealthcare.

Non-Medicare retirees and spouses under age 65 who take the City's health insurance and live in the Milwaukee area, can utilize Froedtert FastCare® Clinic services at no cost. Covered members can visit six approved Froedtert FastCare® Clinic locations to receive high quality care (see page 9 for more information).

The City will continue to offer the UnitedHealthcare (UHC) Choice EPO and UHC Choice Plus PPO plans to retirees in 2021. **Medicare Retirees have a choice of three different group health plan options including the two City sponsored UHC Choice and Choice Plus plans and a Milwaukee Retiree Association (MRA) Group Medicare Advantage plan**. The MRA, in cooperation with National Benefits Consultants, Inc. (NBCI), offers a Medicare Advantage (MA-PD) low premium ($13 per month) plan that provides a great value to Medicare retirees. Over 1,200 Medicare retirees enroll in these plans and have been for over ten years. The Medicare Advantage plan is a comprehensive plan with a lower premium and a benefit design different from the City's UHC Medicare retiree health plans. Retirees will receive a separate packet with information from MRA and NBCI regarding this option. For more information on the Medicare Advantage plan, contact National Benefit Consultants at 800-875-1505 or 262-201-4370.

Retiree members without Medicare enrolled in the City's UHC plan have pharmacy benefits through OptumRx with a 20% coinsurance and a $75 maximum for a monthly prescription. Members can also receive a three month supply of medication through mail order with a maximum payment of $150. Medicare eligible members in the City's Medicare UHC plans have pharmacy benefits through a UHC Medicare Part D drug plan. Medicare members have a 20% coinsurance with a maximum of $75 per month or $150 for a three month supply.

Retirees enrolled in City sponsored UHC plans **MUST** notify the ERS in writing by Friday, November 20, 2020 if switching to a non-City plan. Retirees can return to the City's health plan (during open enrollment or a qualifying event) as long as coverage is maintained elsewhere after leaving the City's plans. City sponsored cancellation and enrollment/change forms can be found on the ERS website www.cmers.com/CMERS_RD/Forms.htm.

Due to the ongoing pandemic, there will be no in-person open enrollment fairs during the fall of 2020. ERS will be holding online virtual sessions where members can participate to get their questions answered. Information about these online sessions will be posted on ERS's website (www.cmers.com) by mid-October. Retirees may also reach out to ERS, DER, UHC, OptumRx and National Benefit Consultants with questions. Contact information is also listed in the back of this guide.

DER Benefits Team

Benefit Basics

This guide includes helpful information for all City of Milwaukee Retirees and is a useful resource as retirees make important decisions regarding health plan choices for 2021. The City's open enrollment period is the only opportunity during the calendar year to make benefit changes outside of a qualifying life event/change in family status (see below for more information).

Information contained in this guide pertains to both Non-Medicare and Medicare Retirees and includes health and pharmacy information for City Sponsored UHC Plans and the Milwaukee Retiree Association (MRA) Group Medicare Advantage Plan. Any questions about retiree benefits should be directed to the Employes' Retirement System (ERS) at 414-286-3557. The Department of Employee Relations (DER) benefits division does not handle retiree benefits.

2021 Benefit Providers

Benefits	Provider
Medical Coverage – City UHC Plans	UnitedHealthcare
Medical Coverage – MRA Group Medicare Advantage Plan	Aetna
Pharmacy Coverage for non-Medicare Retirees	OptumRx
Pharmacy Coverage for Medicare Retirees – City Plans	UnitedHealthcare Medicare Part D
Froedtert FastCare® Clinics (Non-Medicare Retirees)	Froedtert & the Medical College of Wisconsin
Life Insurance	MetLife
Deferred Compensation 457 Retirement Plan	Voya/Deferred Compensation
Pension Fund	Employes' Retirement System

31 Day Rule for Retiree Benefit Plan Coverage

Retired employees are responsible for keeping their enrollment status current and notifying ERS within 31 days of births, adoptions, marriages, divorces, changes in dependent status, deaths and Medicare coverage. Coverage for dependents is effective the date of the family status change, provided retirees notify ERS within 31 days of the event (marriage, birth, adoption, placement of dependent). Members must provide proof of a marriage certificate, birth certificate and include social security numbers for each dependent enrolling in benefits. Non-compliance with coverage eligibility rules may expose members to additional costs or removal of dependents from the plan.

Qualified Life Events / Change in Family Status

Generally, retirees can only change benefit elections, including dropping coverage, during the annual open enrollment period. However, retirees may change benefit elections during the year if they experience a qualified life event/change in family status, including:

- Marriage
- Divorce or legal separation
- Birth of a child
- Death of a spouse or dependent child
- Adoption of or placement for adoption of a child
- Change in employment status of retiree, spouse or dependent child
- Qualified medical child support order
- Entitlement to Medicare or Medicaid

The Summary Plan Description describes the health benefits available to retirees and covered dependents and is available on the ERS and DER benefits website. It provides greater details on who is eligible, when coverage begins, when coverage can be changed, covered and excluded services, and how benefits are paid.

One-Family Plan Rule

City employees and retirees who are married to each other may only carry one City health plan between them. Members are required to report their marriage to ERS, along with a copy of the marriage certificate, within 31 days of the date of marriage. Members may have additional costs if they fail to report their marriage and will have to wait until the open enrollment period to enroll their spouse.

Enrollment Status

Retirees are responsible for keeping their enrollment status, including births, marriages, divorce, Medicare entitlement and other family status changes current by contacting ERS and completing the proper waiver or enrollment forms. See the enrollment instructions on page 16 for more information.

Dependent Coverage

Retiree's eligible dependents may also participate in the City's health plans. Retiree dependents may not enroll in health or dental benefits unless the retiree is also enrolled. An eligible Dependent is considered to be:

- A retiree's legally married spouse
- A retiree or spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom the retiree or spouse are the legal guardian. Coverage for dependent children is through the end of the month the dependent turns 26, regardless of school or marital status
- A child of a dependent child (until the dependent child, who is the parent, turns 18)
- A child for whom coverage is required through a Qualified Medical Child Support Order or other court or administrative order

Outside Health Coverage

- With the exception of Medicare Part A & B, members with other coverage through separate employment, 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 an outside health plan. Members must notify ERS and complete the proper paperwork if waiving coverage. When a member loses other coverage, they can re-enroll in City retiree coverage. Members that terminate City of Milwaukee coverage may re-enroll during open enrollment or through a qualifying event. **Members who leave the City's health plan must maintain health coverage elsewhere or they cannot return to a City sponsored health plan.**

Medicare Eligible Notices

- It is the member's responsibility to be properly enrolled in Medicare Part A and Part B when participating in the City's retiree health plan coverage (or COBRA) when Medicare-eligible due to Social Security disability or at age 65. Medicare Part A and B must be in place when participating in City plan coverage in which Medicare is the primary payer. Members should plan in advance for Medicare enrollment so it is in effect on the date needed. If Medicare is not properly in place, members may experience claim related issues and additional expenses from gaps in coverage.
- Medicare eligible members enrolled in the City's UHC plans are automatically enrolled in the UnitedHealthcare MedicareRx Group Part D plan. It is not necessary for members to join their own Part D plan and doing so will interfere with enrollment in the City's Part D group plan coverage. Members may only participate in one Part D plan at a time.
- Medicare members must include a copy of the member, spouse and adult dependent (if applicable) Medicare I.D. card with the enrollment form within 31 days that Medicare is in place in order to be charged the correct health plan premium rate. Failure to show the card within the 31 day timeframe can result in members paying a higher premium. No refunds will be given after the 31 day deadline for incorrect premiums.
- Members, spouses and plan dependents under 65 and eligible for Medicare as a result of a Social Security disability or duty disability must be enrolled in Medicare Part A and Part B. This is a requirement of all City sponsored health plans. Refer to the guide "Who Pays First" on the ERS website.
- Call 1-800-772-1213 or visit the local Social Security Office for questions regarding Medicare Part A and Part B entitlement, eligibility and enrollment. Members can also enroll at www.ssa.gov and access additional Medicare benefits information by visiting www.medicare.gov or calling 1-800-Medicare.

Open Enrollment (October 26 through November 20, 2020)

Retirees have the opportunity during the City's open enrollment period to newly enroll or make adjustments to existing benefits. Due to the ongoing pandemic, there will be no in person open enrollment events during the fall of 2020 and ERS will be holding virtual events to assist retirees with benefits enrollment and related questions.

- In 2021, the City is changing two different benefit rules: Employees who separate from the City will have insurance coverage through the end of the month they separate and dependents who turn age 26 will have insurance coverage through the end of the month they turn age 26.
- Members that have questions regarding retiree benefits or need help enrolling in or changing benefits should contact the ERS at 414-286-3557 or norm@cmers.com. DER Employee Benefits does not handle retiree benefits.
- There will be benefit design changes for all retirees enrolled in the City's UnitedHealthcare 2021 health plans. These include changes outlined below to the deductible, out-of-pocket maximum and the Medicare coordination for Medicare covered members (see page 12).

ERS will be holding online virtual sessions where retirees may participate to get their questions answered. Information about these online sessions will be posted on ERS's website (www.cmers.com) by mid-October.

2021 Health Plan Options for Retirees

The following health plans are available for Retirees in 2021.

1. **City Sponsored UnitedHealthcare (UHC) Choice Plan:** An EPO plan that allows members to use any providers in the UHC network, which is nearly identical to the network of providers in the Choice Plus PPO plan, except it does not allow members to use providers out-of-network.
2. **City Sponsored UnitedHealthcare (UHC) Choice Plus Plan**: A PPO plan that allows members to use providers in the UHC network and out-of-network as well. Members may pay an additional cost for using out-of-network providers.
3. **MRA Sponsored Aetna Group Medicare Advantage Plan**: An extended service PPO Group Medicare Advantage Plan with a low monthly premium of $13. Retirees must be enrolled in Medicare to participate in this plan.

City of Milwaukee UHC Choice EPO

- Provides uniform City benefits through in-network providers.
- Has a national network with over 650,000 physicians and health care professionals and over 5,000 hospitals throughout the United States.
- Members can go to any UHC network provider in the United States.
- Members enrolling in this plan do not need to select a primary care physician (PCP).
- All emergency services are covered as "in-network," with in-network deductible and coinsurance.
- All preventive services, as defined by UHC and coded by physicians are covered at 100% without any deductible or coinsurance.
- If a provider leaves the UHC Choice network before the end of the plan year, members must see a new provider in the UHC Choice network or pay the provider expense out-of-pocket. Provider contracts are established throughout the year and they may choose not to continue with the contract at the renewal date.
- Call UHC at 1-800-841-4901 to verify providers and hospitals are in-network or visit www.myuhc.com.

City of Milwaukee UHC Choice Plus PPO

- Provides uniform City benefits through both in-network and out-of-network providers.
- Has higher deductibles and coinsurance—see the medical plan options table for more information.
- Has a national network with over 650,000 physicians and health care professionals and over 5,000 hospitals throughout the United States.
- Members can go to any UHC network or non-network provider in the United States. The member will pay more to visit a non-network provider.
- Members enrolling in this plan do not need to select a primary care physician (PCP).
- All emergency services are covered as "in-network," with in-network deductible and coinsurance.
- All preventive services, as defined by UHC and coded by physicians are covered at 100% without any deductible or coinsurance.
- If a provider leaves the UHC Choice Plus network before the end of the year, members can continue to see that provider, but will have to pay the higher deductible and coinsurance for an out-of-network provider
- Call UHC at 1-800-841-4901 to verify providers and hospitals are in-network or visit www.myuhc.com.

2021 Health Plan Options for Retirees

Milwaukee Retiree Association (MRA Sponsored) Aetna Group Medicare Advantage Plan

- Includes Medicare Parts A and B medical benefits, Part D prescription drug benefit, plus more benefits not covered by original Medicare.
- Hundreds of nationwide network doctors or hospitals to choose from.
- Ability to use providers in or out-of-network at the same cost.
- If members choose to see an out-of-network provider, they must be eligible to receive Medicare payments and willing to accept the plan. Members will pay the in-network cost share.
- Offers preventive benefits beyond original Medicare including SilverSneakers® fitness.
- No medical plan deductible.
- Members have limits on out-of-pocket medical plan costs.
- Guaranteed acceptance as long as eligibility requirements are met.
- Includes special programs to help members manage health conditions.
- Informational packets available by calling National Benefit Consultants, Inc. 800-875-1505 or 262-201-4370.

Important Enrollment Reminders

- **Members that are not making health benefit changes in 2021 do not need to re-enroll**.
- Members wishing to change enrollment between the UHC Choice and UHC Choice Plus plan need to complete a health enrollment form through ERS.
- Medicare members that leave the City plan and take the MRA Medicare Advantage plan or another outside plan will need to notify the ERS staff in writing. See page 16 for details.
- Members who leave the City's health plan must maintain health coverage elsewhere or they cannot return to a City sponsored plan.
- Members that have questions regarding retiree benefits should contact the ERS at 414-286-3557. DER Employee Benefits does not handle retiree benefits.
- All retiree enrollment forms must be turned in to the ERS office on or before 4:30 pm Friday, November 20, 2020.

Summary of Health Benefits for Non-Medicare Members

This summary is intended to highlight retiree benefits and should not be relied upon to fully determine coverage. Pre-service authorization is required for certain services. The Summary Plan Description (SPD) shall prevail and can be found at http://www.milwaukee.gov/healthbenefits. The benefit design may change during the year based on Common Council action.

Plan Provisions	UHC Choice EPO Plan	UHC Choice Plus PPO Plan	
	Network Only Benefits	Network Benefits	Non-Network Benefits
Annual Deductible (member pays)			
Individual	$1,500 per year	$3,000 per year	$6,000 per year
Family	$3,000 per year	$6,000 per year	$12,000 per year
Out-of-Pocket Maximum (member pays) includes deductible/coinsurance			
Individual	$3,000 per year	$6,000 per year	$12,000 per year
Family	$6,000 per year	$12,000 per year	$24,000 per year
Coinsurance (plan pays)			
Individual	80%	80%	60%
Family	80% until member responsibility reaches $1,500, not to exceed $3,000 per family	80% until member responsibility reaches $3,000, not to exceed $6,000 per family	60% until member responsibility reaches $6,000, not to exceed $12,000 per family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Emergency Services (the ER copay applies to the out-of-pocket maximum)	$250 member copay per visit	$250 member copay per visit	$250 member copay per visit
Physician Fees	*60% after deductible	*60% after deductible	60% after deductible
*Coinsurance increases to 80% for UHC premium tier 1 provider or non-evaluated provider			
Preventive Care (for more information about preventive services, visit www.uhc.com/health-and-wellness/preventive-care)	100%; deductible does not apply	100%; deductible does not apply	60% after deductible
Ambulance Services (emergency and approved non-emergency)	80% after deductible	80% after deductible	80% after deductible
Autism Spectrum Disorder Services	80% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible	60% after deductible
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years			
Hearing Aids (Limited to one hearing aid per ear, every three years)	80% after deductible	80% after deductible	60% after deductible
Home Health Care (limited to 60 visits per calendar year)	80% after deductible	80% after deductible	60% after deductible
Hospice Care	80% after deductible	80% after deductible	60% after deductible
Hospital – Inpatient Stay	80% after deductible	80% after deductible	60% after deductible
Lab, X-ray and Diagnostics - Outpatient	80% after deductible	80% after deductible	60% after deductible
Mental Health Services	80% after deductible	80% after deductible	60% after deductible
Rehabilitation Services - Outpatient Short-term outpatient rehabilitation for Physical therapy, Occupational therapy, Speech therapy, Pulmonary rehabilitation therapy, Cardiac rehabilitation therapy and Respiratory therapy. Pre-authorized therapies are limited to a maximum of 50. See SPD for more details	80% after deductible	80% after deductible	60% after deductible

Summary of Health Benefits for Non-Medicare Members

This summary is intended to highlight retiree benefits and should not be relied upon to fully determine coverage. Pre-service authorization is required for certain services. The Summary Plan Description (SPD) shall prevail and can be found at http://www.milwaukee.gov/healthbenefits. The benefit design may change during the year based on Common Council action.

Plan Provisions	UHC Choice EPO Plan	UHC Choice Plus PPO Plan	
	Network Only Benefits	Network Benefits	Non-Network Benefits
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (120 day maximum per calendar year)	80% after deductible	80% after deductible	60% after deductible
Substance Abuse Disorder	80% after deductible	80% after deductible	60% after deductible
Urgent Care	80% after deductible	80% after deductible	60% after deductible
Vision Exams (one routine vision exam per year)	80% after deductible	80% after deductible	60% after deductible
No additional discounts for frames or lenses			

The plan has limited oral surgery benefits. Please refer to the medical Summary Plan Documents for clarification.

The above table provides selected highlights of the City of Milwaukee retiree benefits program. It is not a legal document and shall not be construed as a guarantee of benefits or health coverage with the City of Milwaukee. Benefit plans are governed by master policies, contracts and plan documents. Discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents.

Prescription Drug Coverage	OptumRx
Prescription Drug Coinsurance (member pays) does not apply to medical deductible or out-of-pocket maximum	
Retail (30 day supply)	20% ($75 max)
Mail order (90 day supply)	20% ($150 max)
Prescription Drug Out-of-Pocket Maximum	$3,600 Individual/ $7,200 Family

Froedtert FastCare® Walk-In Clinics

Non-Medicare retirees and spouses under age 65 enrolled in the City's UnitedHealthcare (UHC) insurance can receive expert care from Froedtert & the Medical College of Wisconsin providers at FastCare® clinics on a walk-in basis, without an appointment, during convenient hours. Services include diagnosis and treatment of non-emergent minor illnesses and injuries such as sore throats, ear infections, sinus infections, flu or cold symptoms, skin rashes, sprains/strains and pink eye. Retirees, spouses and dependents (ages 18 months and older) with the City's UHC health insurance have access to the six Froedtert FastCare® clinics listed below at no charge when they present their UHC insurance card.

NEW Retirees can schedule an appointment and view wait times at Froedtert FastCare® Clinics by visiting www.froedtert.com/fastcare or by downloading the Froedtert and MCW app and selecting the clinic they plan to visit.

Downtown Froedtert FastCare® Location	Address	Phone	Hours
Froedtert & MCW McKinley Health Center	1271 N. 6th St., Milwaukee	414-978-9037	Mon-Fri 10 a.m. – 7 p.m. Saturday 9 a.m. – 1 p.m. Sunday 9 a.m. – 1 p.m.
Froedtert FastCare® Locations at Meijer	**Address**	**Phone**	**Hours**
Greenfield Meijer	5800 W. Layton Ave.	262-532-3067	Mon-Fri 9 a.m. – 8:30 p.m. Saturday 9 a.m. – 6 p.m. Sunday 10 a.m. – 5 p.m.
Sheboygan Meijer	924 Taylor Dr.	920-395-7210	
Sussex Meijer	N51W24953 Lisbon Rd.	262-532-8691	
Waukesha Meijer	801 E. Sunset Dr.	262-532-3691	
West Bend Meijer	2180 S. Main St.	262-532-3127	

Summary of Health Benefits for Medicare Members

This summary is intended to highlight retiree benefits and should not be relied upon to fully determine coverage. Pre-service authorization is required for certain services. The Summary Plan Description (SPD) shall prevail and can be found at http://www.milwaukee.gov/healthbenefits. The benefit design may change during the year based on Common Council action. The coordination style for Medicare members is changing and members will have to pay their portion of the City's health plan benefit design for claims covered as secondary under UnitedHealthcare.

Plan Provisions	UHC Choice EPO Plan	UHC Choice Plus PPO Plan	
	Network Only Benefits	Network Benefits	Non-Network Benefits
Annual Deductible (member pays)			
Individual	$1,500 per year	$3,000 per year	$6,000 per year
Family	$3,000 per year	$6,000 per year	$12,000 per year
Out-of-Pocket Maximum (member pays) includes deductible and coinsurance			
Individual	$3,000 per year	$6,000 per year	$12,000 per year
Family	$6,000 per year	$12,000 per year	$24,000 per year
Coinsurance (plan pays)			
Individual	80%	80%	60%
Family	80% until member responsibility reaches $1,500, not to exceed $3,000 per family	80% until member responsibility reaches $3,000, not to exceed $6,000 per family	60% until member responsibility reaches $6,000, not to exceed $12,000 per family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Emergency Services (the ER copay applies to the out-of-pocket maximum)	$250 member copay per visit	$250 member copay per visit	$250 member copay per visit
Physician Fees	*60% after deductible	*60% after deductible	60% after deductible
*Coinsurance increases to 80% for UHC premium tier 1 provider or non-evaluated provider			
Preventive Care (for more information about preventive services, visit http://www.uhc.com/health-and-wellness/preventive-care)	100%; deductible does not apply	100%; deductible does not apply	60% after deductible
Ambulance Services (emergency and approved non-emergency)	80% after deductible	80% after deductible	80% after deductible
Autism Spectrum Disorder Services	80% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible	60% after deductible
Limed to a single purchase of Durable Medical Equipment (including repair and replacement) every three years			
Hearing Aids (Limited to one hearing aid per ear, every three years)	80% after deductible	80% after deductible	60% after deductible
Home Health Care (limited to 60 visits per calendar year)	80% after deductible	80% after deductible	60% after deductible
Hospice Care	80% after deductible	80% after deductible	60% after deductible
Hospital – Inpatient Stay	80% after deductible	80% after deductible	60% after deductible
Lab, X-ray and Diagnostics - Outpatient	80% after deductible	80% after deductible	60% after deductible
Mental Health Services	80% after deductible	80% after deductible	60% after deductible

Summary of Health Benefits for Medicare Members

This summary is intended to highlight retiree benefits and should not be relied upon to fully determine coverage. Pre-service authorization is required for certain services. The Summary Plan Description (SPD) shall prevail and can be found at http://www.milwaukee.gov/healthbenefits. The benefit design may change during the year based on Common Council action. **The coordination style for Medicare members is changing and members will have to pay their portion of the City's health plan benefit design for claims covered as secondary under UnitedHealthcare.**

Plan Provisions	UHC Choice EPO Plan	UHC Choice Plus PPO Plan	
	Network Only Benefits	Network Benefits	Non-Network Benefits
Rehabilitation Services - Outpatient Short-term outpatient rehabilitation for Physical therapy, Occupational therapy, Speech therapy, Pulmonary rehabilitation therapy, Cardiac rehabilitation therapy and Respiratory therapy. Pre-authorized therapies are limited to a maximum of 50. See SPD for more details	80% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (120 day maximum per calendar year)	80% after deductible	80% after deductible	60% after deductible
Substance Abuse Disorder	80% after deductible	80% after deductible	60% after deductible
Urgent Care	80% after deductible	80% after deductible	60% after deductible
Vision Exams (one routine vision exam per year)	80% after deductible	80% after deductible	Not covered
No additional discounts for frames or lenses			

The plan has limited oral surgery benefits. Please refer to the medical Summary Plan Documents for clarification.

The above table provides selected highlights of the City of Milwaukee retiree benefits program. It is not a legal document and shall not be construed as a guarantee of benefits or health coverage with the City of Milwaukee. Benefit plans are governed by master policies, contracts and plan documents. Discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents.

Prescription Drug Coverage	UnitedHealthcare MedicareRx
Prescription Drug Coinsurance (member pays) does not apply to the medical deductible or out-of-pocket maximum	
Retail (30 day supply)	20% ($75 max)
Mail order (90 day supply)	20% ($150 max)
Prescription Drug Out-of-Pocket Maximum	$3,600 Individual/ $7,200 Family

Coordination of Benefits for Medicare Members

IMPORTANT: Starting in 2021 the coordination style between the City's UnitedHealthcare plans and Medicare is changing. Only payments made by the member will count towards the member's UnitedHealthcare deductible, coinsurance and out-of-pocket maximum for claims paid as secondary under UHC. Payments made by Medicare will not count towards the member's UnitedHealthcare deductible, coinsurance and out-of-pocket-maximum. See below for examples regarding the new coordination style.

Medicare (Primary) and UHC (Secondary) For Medicare Members in City Sponsored Plans

For City Sponsored Plans, how does coordination of benefits work as a Medicare member?

On a single medical bill there may be portions paid by Medicare, portions paid by UHC and portions paid by the member until the deductibles, coinsurance and out of pocket maximum are reached. Medicare is the primary payer and UHC is the secondary payer for Medicare members enrolled in City sponsored health plans. The examples below use the UHC Choice Plus plan and 2020 Medicare A and B amounts.

- Medicare A (Hospital portion) has a $1,408 (2020) annual deductible and then Medicare pays at 100%
- Medicare B (Major Medical portion) has a $198 (2020) annual deductible and then Medicare pays at 80%. The UHC Choice Plus plan has a $3,000 deductible, 20% coinsurance up to $3,000, and then pays at 100% for Medicare eligible expenses. City members do not have a Choice/Choice Plus coinsurance for any Medicare eligible services.

Example #1: Member receives a $3,000 bill under Medicare Part B (Major Medical Portion)

Medicare Part B pays $0 on the first $198 of services.
UHC Choice Plus pays $0 on the first $3,000 of service.
Member pays $198 of the $3,000 charge. Member's Medicare Part B deductible is met.

There is a $2,802 balance before the UHC Choice Plus $3,000 deductible is reached.
Medicare Part B pays 80% of the $2,802 or $2,242.
Member pays $560

The member's $758 payment will count towards their $3,000 UHC Choice Plus deductible. The remaining deductible balance is $2,242.

Total out of pocket cost for member with $3,000 Medicare Part B bill: $758

Example #2: Member receives $3,000 bill under Medicare Part A (Hospital Portion)

Medicare Part A pays $0 on the first $1,408 of services.
UHC Choice Plus pays $0 on the first $3,000 of services.
Member pays the first $1,408 in cost. Member's Medicare Part A deductible $1,408 is met

There is a $1,592 balance before the UHC Choice Plus $3,000 deductible is met.
Medicare Part A pays $1,592 (as long as services are eligible for Medicare)
Member pays $0

UHC Choice Plus deductible, $3,000, has not been met. The member may be responsible for additional costs not covered by Medicare Part A

Total out of pocket cost for member with $3,000 Medicare Part A bill: $1,408.

Important Notes

- 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, members may have co-insurance costs of 20% or 40% depending on the provider's UHC Tier 1 status and the services that are not eligible for Medicare.

OptumRx Pharmacy Benefits for Non-Medicare Members

OptumRx is the City's pharmacy benefit manager (PBM) and manages and processes pharmacy claims. OptumRx also answers pharmacy benefit questions and helps educate members about programs offered through the plan.

How do members find a participating retail pharmacy?

The OptumRx pharmacy network includes thousands of chain and independent pharmacies nationwide. Visit optumrx.com and find the Pharmacy locator tool from the Member tools menu or call the customer service number on the back of the health plan ID card.

What tools are available on the OptumRx website?

The optumrx.com website is easy to use and offers a fast, safe and secure way to refill home delivery prescriptions, manage accounts, get drug information and pricing, and more. Registration is free and there are no extra fees to order home delivery prescriptions online.

Why should members show their ID card when filling prescriptions?

The pharmacy uses information on the ID card to send prescription claims to OptumRx for processing. Showing the ID card also ensures that members pay the lowest possible cost, even for a low-cost generic medication.

Are coupons for brand-name medications really a good deal?

Drug companies use copay coupons to increase sales of brand-name medications. They offer coupons or other kinds of discounts that lower or eliminate the cost for a specific drug. While a coupon means the member will pay less, the total or true cost of the brand-name medication doesn't change. Many coupons expire after a short trial period. When they do, participants may end up paying much more for a brand name medication.

How can members keep prescriptions affordable?

Use generic medications whenever possible. If a generic isn't available, members should ask their doctor if there is a brand name medication or a different generic medication that's less expensive.

When can members refill prescriptions?

Prescriptions can usually be refilled after approximately two-thirds of the medication is used. For example, 30-day prescriptions may be refilled after 23 days and 90-day prescriptions may be refilled after 68 days.

How do members find out which medications are covered by the plan?

A Prescription Drug List (PDL) is a list of brand-name and generic medications covered by the plan. These medications are the best value in quality and price, which can help control rising drug costs. The most current PDL can be found at optumrx.com or call customer service at the number on the back of the health plan ID card.

What is Mail Service Member Select?

Mail Service Member Select is a home delivery program that makes it easy to receive ongoing medications by mail. Home delivery has advantages: Members may pay less for their medication with a three-month supply, get free standard shipping on medication delivery and talk to a pharmacist who can answer questions any time, any day.

Members can choose to fill a maintenance medication through OptumRx or a retail pharmacy. If a member chooses a retail pharmacy, they must disenroll from the Mail Service Member Select program. Two retail pharmacy fills of maintenance medications are allowed before a member must choose. If action is not taken after the second retail fill, members may pay more for their medication until a decision is made. To disenroll call 1-800-841-4901.

Diabetic Benefits

The following provides an explanation of the diabetic claims processes for diabetic equipment and supplies. These benefits are for active, non-Medicare employees. Please refer to the plan summary for details.

Item	Claim Process
Durable medical equipment: insulin pumps and supplies used for insulin pumps	Processed through the medical benefits for all UHC plans.
Diabetic testing supplies: test strips, syringes, needle tips, lancets, etc.	Processed through the OptumRx pharmacy benefit for all members covered under the UHC plans.

OptumRx Contacts

Pharmacy Benefit Contact	Phone
OptumRx Customer Service	800-841-4901
OptumRx Home Delivery	866-837-9242
BriovaRx Specialty	855-427-4682

UnitedHealthcare MedicareRx for Medicare Members

Medicare members enrolled in City sponsored UHC Choice and Choice Plus plans have the UnitedHealthcare MedicareRx for Groups Part D Prescription Drug Plan with a 20% coinsurance. Medicare members must use the prescription drug card from UnitedHealthcare MedicareRx.

Why UnitedHealthcare® MedicareRx?

The UnitedHealthcare® MedicareRx for Groups (PDP) plan helps protect members from unexpected changes in prescription drug costs. 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 chains as well as independent neighborhood pharmacies.
- Member convenience and savings with preferred mail service pharmacy.
- Customer Service available from 8 a.m. to 8 p.m. Central time, 7 days a week
- Additional coverage through UnitedHealthcare RxSupplement which provides additional coverage to member's Medicare Part D coverage.
- Health Innovations offers low cost hearing aids to help members experiencing hearing issues.

How to use the prescription drug ID card

Present the member ID card to a pharmacist whenever filling a prescription at a participating retail pharmacy. The card displays the member ID number which is needed by the pharmacist to process the prescriptions. To find a retail pharmacy and covered medications, go to www.UHCRetiree.com or call UnitedHealthcare at 1-866-465-0572, 8:00 a.m. to 8:00 p.m. Central time, 7 days a week.

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 and access online tools:

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

Registering is simple and safe, and member's information is secure and confidential.

Diabetic Benefits

The following provides an explanation of the diabetic claims processes for diabetic equipment and supplies. Please refer to the Summary Plan Description or Medicare's Coverage of Diabetes Supplies and Services on the ERS website.

Item	Claim Process
Durable medical equipment: insulin pumps and supplies used for insulin pumps (includes insulin used for the pump only)	Processed through the medical benefits where Medicare is primary and UHC is secondary for City sponsored UHC plans.
Diabetic testing supplies: test strips, syringes, needle tips, lancets, etc.	Some diabetic testing supplies such as test strip and lancets are processed through Medicare Part B, while other diabetic supplies are processed through the UnitedHealthcare MedicareRx pharmacy benefit for all members covered under the UHC plans.

UnitedHealthcare Services

For retirees and spouses enrolled in the City sponsored UHC health plans

The following UnitedHealthcare (UHC) resources may help members better understand their health benefits and provide ways to maintain or improve their health and reduce out-of-pocket costs. These tools are for members enrolled in the City's sponsored UHC health plans and designed to help members make more informed health decisions and provide access to online programs and services to help live the healthiest life possible.

UnitedHealthcare App

The UnitedHealthcare App provides instant access to participant's important health information including finding a physician, checking the status of a claim and speaking directly with a health care professional. Search for UnitedHealthcare and download from the App store for iPhone® or Google® Play for Android.

UHC Find Care and Costs

Research treatment options based on specific health situations and learn about the recommended care, estimated costs and time to treat various medical conditions. Look for the cost estimating link at myuhc.com under "Find Care and Costs."

Real Appeal Weight Management Program

Real Appeal is an online weight management program available to members under age 65 and spouses and dependents 18 and older with a BMI of 23 or greater. Real Appeal helps members and spouses make small, manageable changes that lead to lasting weight loss. Eligible members who join the program are connected with a personal coach and receive a Real Appeal Success Kit with the tools needed for successful weight loss. Participation and enrollment is done using a smartphone, tablet or personal computer at cityofmilwaukee.realappeal.com.

UHC Virtual Visits

See and talk to a doctor from a mobile device, tablet or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription for pick up at a local pharmacy. Not all medical conditions can be treated with a Virtual Visit. The average cost for members enrolled in the City's UHC health benefits plan is $50 per visit. Register through myuhc.com. Call the number on the health plan ID card for assistance.

Telehealth Visits

Access to providers through telehealth visit was expanded in 2020 in response to the COVID-19 pandemic and includes medical, physical therapy, speech therapy, occupational therapy, and behavioral health visits. UHC anticipates telehealth coverage will continue into 2021.

UHC Emotional Support Line

The UHC Emotional Support Line, 1-866-342-6892, has caring professionals that will connect people to resources 24/7. This service is free of charge to both UHC and non-UHC members.

UnitedHealthcare®

Tier 1 Providers

Members receive the highest quality care at the lowest cost for their family by seeing Tier 1 Providers. Doctors in numerous medical specialties are evaluated using national standards for quality and local benchmarks for cost efficiency. Members pay a lower coinsurance of 20% (not 40%) by choosing a Tier 1 Premium Provider. If a doctor's specialty is not evaluated, members will automatically pay at the 20% coinsurance level. Login to myuhc.com and the UnitedHealthcare App for more information.

UHC myuhc.com

The tools and information at myuhc.com are both practical and personalized for participants to get the most out of their benefits. Learn about health conditions, treatments and costs, find in-network providers and order mail order medications. Register at myuhc.com to get started with managing health care coverage and making informed decisions about medical treatments and overall wellness. Call the number on the health plan ID card for assistance.

UHC NurseLine

One toll-free number connects participants with a registered nurse who will provide personalized health information and assistance. Available 24 hours a day, seven days a week. Call the Customer Service number on the plan ID card or visit myuhc.com.

Sanvello App

Sanvello is an app that offers clinical techniques to help dial down the symptoms of stress, anxiety and depression. This services is free of charge to both UHC and non-UHC members. Download from the App store. The premium version is available to UHC members at no additional cost.

Open Enrollment

ERS Enrollment Instructions

1) Members making changes must submit a health enrollment/change form and other necessary documents, which are available at the following locations or online: www.cmers.com/CMERS_RD/Forms.htm:
   a) City Open Enrollment Fairs (no in person fairs are being held in 2020)
   b) ERS Office, 789 North Water Street, Suite 300
   c) DER City Hall, Room 706.
2) Members making family status changes like marriage, divorce, adding/removing dependents, etc.:
   a) Complete a Health Enrollment/Change Form, including SECTION A
   b) Place a check ☑ in the appropriate box in SECTION B
   c) Write the name of the affected individual(s) in SECTION C
   d) Complete SECTION D and sign/date SECTION E
3) Members that are waiving City health coverage must contact a Health Insurance Specialist at ERS for an appropriate waiver form or send a letter to the pension office with an effective date.
   a) 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. Members that terminate City of Milwaukee coverage may re-enroll during open enrollment or through a qualifying event. Members who leave the City's health plan must maintain health coverage elsewhere or they cannot return to a City sponsored plan.

Important 2021 Open Enrollment Due Date

All "Retiree" applications should be returned to the ERS office at the address below no later than **4:30 p.m. Friday, November 20, 2020**:

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

Enrollment Form Instructions for members making Health Enrollment changes

- Write "Retiree" in the Job Title box of all enrollment forms.
- A COBRA enrollee will write "COBRA" in the Job Title box.
- Do not write anything in the City Start Date and Return to Work boxes.

Members who are eligible for Medicare Part A and Part B

- City of Milwaukee employees and their spouses (and any Medicare entitled dependents) over the age of 65 or under 65 and disabled must have Medicare Part A and B in place at the time of the City employee's retirement to avoid gaps in coverage and additional medical expenses. Arranging timely Medicare coverage is critical because Medicare becomes the Primary payer of health insurance. Refer to the "Who Pays First" guide on the ERS website.
- Include a copy of the member, spouse and adult dependent (if applicable) Medicare I.D. card with the enrollment form within 31 days that Medicare is in place in order to be charged the correct health plan premium rate. Failure to show the card within the 31 day timeframe can result in members paying a higher premium. No refunds will be given after the 31 day deadline for incorrect premiums.
- It is important for ERS to know a member's Medicare status to ensure members are being charged the correct monthly health insurance premium.
- Members may experience claim related issues and incur additional expenses from gaps in coverage if Medicare is not in place at the correct time.

Benefit Note: It is imperative that all health plan participants entitled to Medicare (whether due to age or disability) be enrolled in both Part A and Part B in a timely manner when covered by COBRA or retiree group health plan coverage. Advance Medicare enrollment planning is recommended to avoid any misunderstandings, timing issues or gaps in coverage when arranging Part A and B Medicare enrollment.

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Milwaukee/ERS, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee/retiree;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The member's becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Employes' Retirement System, 789 North Water Street, Suite 300, Milwaukee, WI 53202, 414-286-3557.

Additional Information – COBRA

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify the City of Milwaukee Employes' Retirement system if the Social Security disability determination changes within 31 days of the change.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

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

COBRA Dental Coverage Note: If you are retiring or otherwise separating and are eligible to continue your dental coverage through COBRA, please note that CarePlus Dental only covers clinics in the Milwaukee area. If you intend to move, you should consider switching to a different dental plan when applying for COBRA.

Glossary

Deductible – The amount members are required to pay each year before the plan begins to pay benefits. Members begin accumulating expenses toward satisfaction of the deductible at the beginning of each benefit year.

Coinsurance – The percentage of the cost members pay when they receive certain health care services after the deductible is met. For UHC Choice Plan, members pay 20% or 40% up to $1,500 single and $3,000 family. For in-network with UHC Choice Plus Plan, members pay 20% or 40% up to $3,000 single and $6,000 family. See below for information on UnitedHealthcare Premium Tier 1 Providers for difference in coinsurance amounts.

Copayment – The flat dollar amount members pay when they receive certain medical care services. Copays may be due at the time of service.

Coordination of Benefits (COB) – If members have Medicare and other health coverage, each type of coverage is called a 'payer'. When there's more than one payer, "coordination of benefits" rules decide who pays first. The "primary" pays what it owes on member bills first, and then the remaining portion is sent to the "secondary payer" to pay. Members should tell doctors and other providers if they have health coverage in addition to Medicare.

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

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

Out-of-Pocket Maximum – The maximum amount members pay during the year for covered health care services. When the annual out-of-pocket maximum is met, the plan pays the full cost of covered expenses for the remainder of the benefit year. Covered expenses (deductibles and coinsurance amounts) apply towards the out-of-pocket maximum.

UnitedHealthcare Premium Tier 1 Providers – Members pay lower coinsurance amounts (20%) 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 20% coinsurance.

Medicare Part A (Hospital) – Medicare Part A covers Medicare inpatient care, including care received while in a hospital, a skilled nursing facility, hospice and, in limited circumstances, at home.

Medicare Part B (Medical) – Medicare Part B (medical insurance) covers services and supplies that are medically necessary to treat member health conditions. This can include outpatient care, preventive services, physician services, ambulance services and durable medical equipment.

Medicare Part D (Prescription Drugs) – Medicare Part D covers the costs of prescription drugs and prescription drug insurance premiums for Medicare eligible members.

Medicare Advantage Plan – Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. Medicare pays these companies to cover Medicare benefits. A Medicare Advantage Plan provides Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance) and Medicare Part D (prescription drug) coverage.

Helpful Resources

Plan	Provider	Phone Number	Website / Email
Deferred Compensation 457 Retirement Plan	Voya Deferred Compensation	844-360-6327 414-286-5541	www.milwaukeedcp.com
Froedtert FastCare® Clinics	Froedtert & the Medical College of Wisconsin	See page 9	www.froedtert.com/fastcare
Life Insurance	MetLife	414-286-3557	www.cmers.com
Medicare Group Advantage Plan (MRA Sponsored)	National Benefits Consultants, Inc.	800-875-1505 262-201-4370	www.nbci.biz
Medicare Health Insurance	US Federal Government	800-633-4227	www.medicare.gov
Pension Fund	Employes' Retirement System	800-815-8418 414-286-3557	www.cmers.com norm@cmers.com
Pharmacy (Medicare)	UnitedHealthcare MedicareRx	866-465-0572	www.uhcretiree.com
Pharmacy (Non-Medicare)	OptumRx	800-841-4901	www.optumrx.com
Home Delivery	OptumRx	866-837-9242	www.optumrx.com
Specialty Medications	BriovaRx	855-427-4682	www.briovarx.com
Retiree Benefits	Employes' Retirement System	800-815-8418 414-286-3557	www.cmers.com norm@cmers.com
Social Security	US Federal Government	800-772-1213	www.ssa.gov
UHC Choice and Choice Plus Plans (City Sponsored)	UnitedHealthcare	800-841-4901	www.myuhc.com

Questions

Members that have questions on medical or pharmacy benefits regarding unpaid bills or problems with service should call the health plan first. DO NOT call the ERS office until the appropriate plan has been contacted. If the situation cannot be resolved through the plan provider ERS will attempt to assist with resolving the problem. Remember to document phone conversations with dates, times and names and save any email correspondence. ERS will ask members for this information to try and resolve the issue.

Compliance Notifications

Important legal notices affecting member health plans are posted on DER's benefits website www.milwaukee.gov/Benefits under "L" Legal Notices.

About This Guide

This benefit guide provides selected highlights of the City of Milwaukee retiree benefits program. It is not a legal document and shall not be construed as a guarantee of benefits or health coverage with the City of Milwaukee. Benefit plans are governed by master policies, contracts and plan documents. Discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents.