MILWAUKEE
PUBLIC SCHOOLS

2020
HEALTH & DENTAL PLANS FOR ACTIVE EMPLOYEES

Includes Life & Disability Insurance Highlights and MPS Employee Wellness Program Information

Effective January 1, 2020

Open Enrollment is October 21 – November 8, 2019

Application Deadline
5:00 p.m. Friday, November 8, 2019 with changes effective January 1, 2020

Open Enrollment Session
Wednesday, October 30, 2019
3:00 – 5:00 p.m.
MPS Central Services – Auditorium
5225 W. Vliet St., Milwaukee, WI 53208

Representatives from the carriers will be available to answer your questions.

Please retain this booklet for future reference.

Office of Human Resources | Department of Benefits, Pension & Compensation

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BENEFIT HIGHLIGHTS

Important benefit highlights and reminders for 2020 are listed on pages 1-2. Please be sure to take the time to read through the Open Enrollment materials carefully and completely even if you do not change plans. New for 2020:

New Insurance Card Effective for January 1, 2020!

Effective January 1, 2020, employees enrolled in the UnitedHealthcare EPO, PPO, or HDHP will receive a new insurance card. There is **no** change to the healthcare provider or the prescription drug provider, however, there will be a change to the Rx Bin # on the insurance cards. Please see page 4 under OptumRx for more information.

Using your new card is crucial to your prescription drug coverage in 2020– your prescriptions will be delayed without it!

Delta Dental EPO To Replace Care Plus Effective January 1, 2020

MPS is replacing Care Plus dental coverage with the same plan to be administered by Delta Dental effective January 1, 2020. This dental coverage is an in-network only dental plan with all Care Plus providers in the network, plus more!

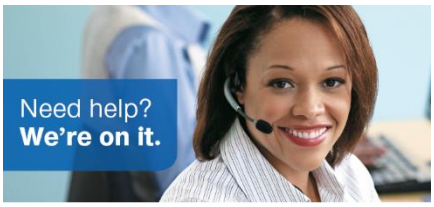
Employees and dependents currently enrolled in the Care Plus dental plan will be automatically transferred to the Delta Dental Dental EPO plan effective January 1, 2020. If you wish to change from the Delta Dental EPO (previously Care Plus) to the Delta Dental PPO plan (the current Delta Dental plan), you must elect it during this Open Enrollment period. If you are enrolled in the Delta Dental PPO plan and do not make any changes, you will remain in the Delta Dental PPO plan effective January 1, 2020. Please note that any orthodontic out-of-pocket already met under the current Care Plus plan will be transferred to the Delta Dental EPO for continuation of this benefit coverage under this plan. For more information see pages 6 and 51 of this booklet.

Do you have questions about The Standard life and disability insurance coverage? Please see pages 8-10 for highlights about these benefits.

UnitedHealthcare Health & Wellness Resources:

Reminders:

UnitedHealthcare Advocate4Me



Members can connect with an Advocate who provides end–to-end support until a healthcare coverage request is resolved. Advocates can tap into expertise in clinical care, emotional health, pharmacy, healthcare costs & medical plan benefits to help each member navigate the health system and get the information he or she needs.

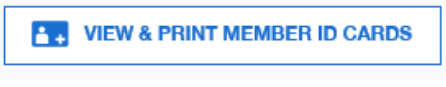
Contact UnitedHealthcare Advocate4Me: Monday- Friday 7 a.m. to 10 p.m. at 1-877-440-5982. Or log on to www.myuhc.com®, select "Help" at the top or bottom of the screen, and then select "We'll Call You" or "Chat Now."

Looking to know more about your health plan options? Sign up for "Benefits 101" - just one of the program offerings from the Wellness On Site menu

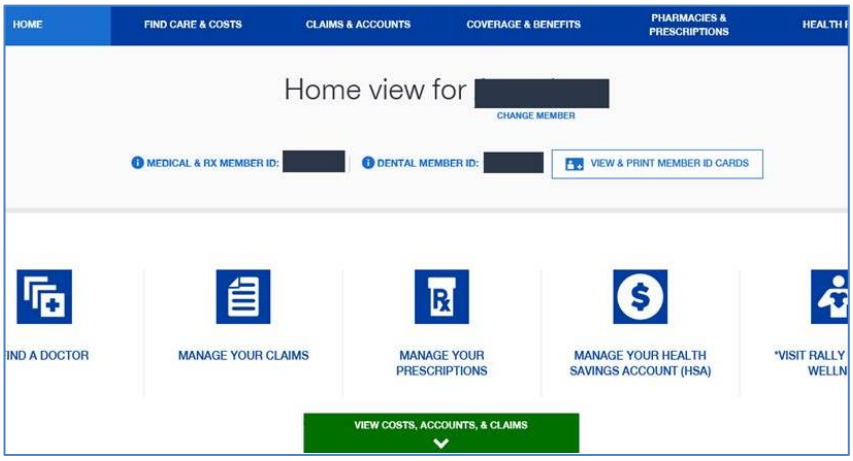
Sign up to learn more about your medical benefits available through Milwaukee Public Schools and UnitedHealthcare. You will gain an understanding of your health plan choices, learn how to access benefits and how to make wise health care decisions using UHC tools. To have this program presented to your school/work site, contact your Wellness Champion to select and enroll in this program from the Wellness On Site menu, or contact Veronica at griffiv1@milwaukee.k12.wi.us. It's a great start to help you live a happy and healthier life.

Need to print a copy of your UHC card?

- Log on to myuhc.com
- Then select:



- When your insurance card appears select:



WHAT ARE MY HEALTH PLAN OPTIONS?

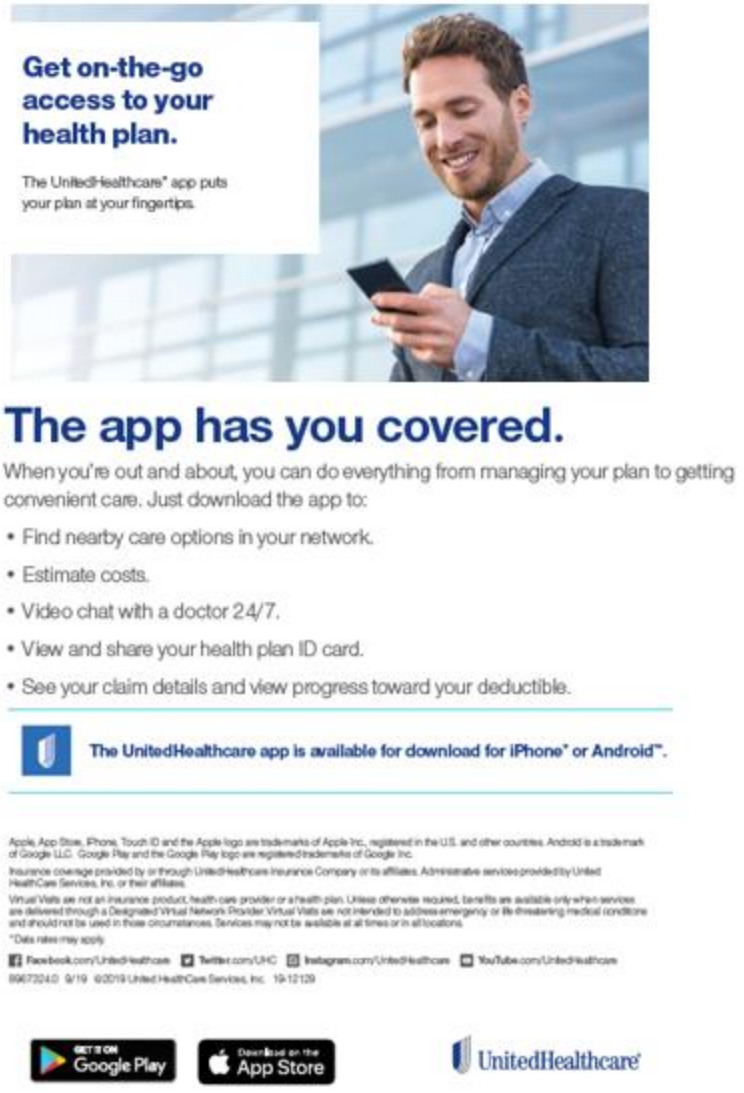
Active Employees

All benefit eligible active employees can participate in the PPO, EPO or High Deductible Health Plan (HDHP). Building Trades unit employees may not participate in the MPS PPO plan, but may enroll in either the EPO or HDHP.

Appendix A on page 43 includes a grid summarizing the benefits and costs associated with the plan; Appendix C on page 53 includes a listing of the monthly premium costs and per-paycheck deductions for each health plan.

What are the differences in Networks between the EPO, PPO and HDHP Plan?

Both the HDHP and PPO plan use the UHC Choice Plus Network. This is an expansive network and these plan designs include both an in-network and out-of-network benefit; although there is higher cost-sharing for out-of-network services (generally you will pay 50% coinsurance for out-of-network services). The EPO plan utilizes the UHC Choice network, which has a substantially similar network of doctors to the PPO and HDHP plan; however, the EPO plan provides no coverage for out-of-network services. Under both networks, members have access to local and national providers without the need for a referral.



Reminders for EPO and PPO Plans

Out-of-Pocket Maximum for EPO and PPO

In calendar year 2020, the EPO and PPO Out-Of-Pocket (OOP) maximum includes deductible and co-payments. Once you reach your OOP limit, you will have no further cost sharing for covered services. Since your OOP includes deductibles it provides a better benefit by limiting the amount of co-pays that you will pay.

In 2020, health plans were required to state an Out-Of-Pocket maximum cost for prescription medications. Once you reach your OOP drug limit, you will have no further cost sharing for covered prescription medications.

Please note that the Out-Of-Pocket limits for the HDHP plan do operate differently. See the next page for notes on the HDHP OOP.

Member-Pay-The Difference on Multi-Source Brand Prescriptions

Under the EPO and PPO, and the preventive prescription co-pay in the HDHP plan (see the next page), there is a feature to encourage use of generic prescriptions. If a brand prescription has a generic equivalent, members will be required to use the generic or pay the difference in cost between obtaining the generic prescription and the brand (i.e. the member will pay the $8 generic co-pay plus the difference in gross cost between the brand and the generic medication).

Preauthorization Requirement on the EPO, PPO and HDHP Plans

There is an expanded list of services that require preauthorization. In most cases, when you are seeing an in-network provider, your health care professional is responsible for obtaining prior approval. When receiving services out-of-network, you are responsible for contacting UHC for prior approval, or the benefit you receive will be reduced. In the benefit charts in Appendix A, services that require preauthorization are designated by a double asterisk (**).

OptumRx

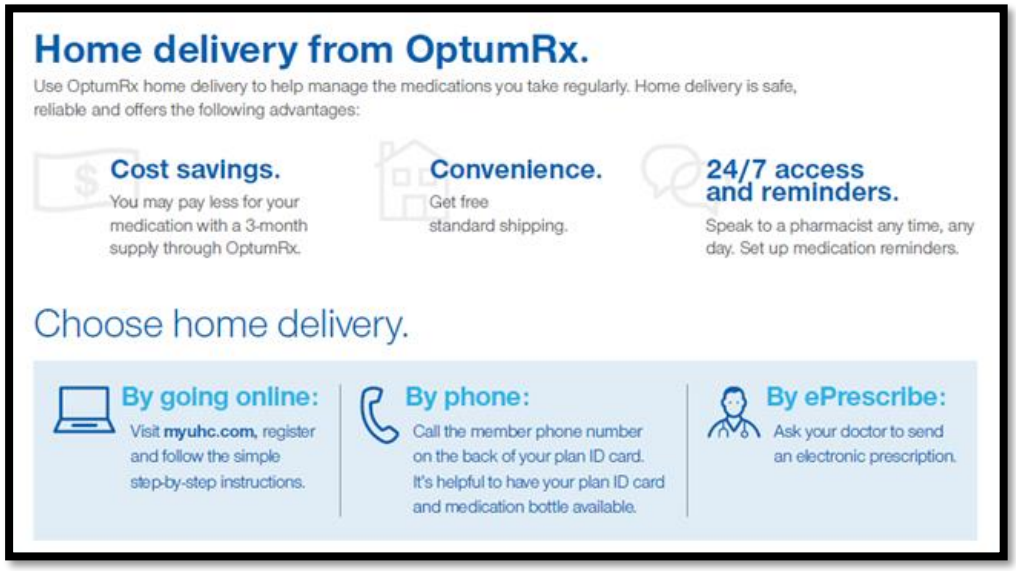
Please note: Effective January 1, 2020, employees enrolled in the UnitedHealthcare EPO, PPO, or HDHP will receive a new insurance card. **Using your new card is crucial to your prescription drug coverage in 2020 – your prescriptions will be delayed without it!**

Retail pharmacy and home delivery (mail order) coverage with the EPO, PPO, and HDHP remains the same in 2020. Prior authorizations for both retail and home delivery that are still active at the end of 2019 will be transferred into 2020. There may be tier coverage changes for new-to-therapy medications.

The prescription drug list (PDL) coverage information is updated twice per year and can be found on mConnect and myuhc.com.

To find information about OptumRx home delivery, prescription drug prices, and more: log in to myuhc.com and select "Manage Your Prescriptions."

Here are some highlights of the home delivery coverage from OptumRx.



Special Notes on the HDHP Plan

The HDHP plan offers employees a health plan with a lower monthly premium cost in exchange for a higher deductible within the plan and the ability to open a Health Savings Account (see below for more information). This gives employees greater control of how they manage their health care costs and an opportunity to save money with a tax advantage.

How does the HDHP deductible work?

Except for preventive care and preventive prescriptions, all health care (including the costs of prescription medication) are subject to the deductible and coinsurance. This means that the plan will pay 80% of covered in-network costs, after the employee has satisfied the in-network deductible; or 50% of covered costs after the employee has satisfied the out-of-network deductible. Unlike the family deductible within the EPO and PPO (which is, in essence, three separate individual deductibles), the HDHP family coverage deductible is an aggregate total that applies to all individuals covered by the plan. The family coverage deductible must be satisfied prior to receiving any coverage from the plan, even if the entire family coverage deductible is satisfied by one member of the family.

How are preventive medical services covered under the HDHP?

Preventive medical care as specified in the health care reform law under the HDHP is covered at 100% and is not subject to either the deductible or coinsurance. There is no cost sharing on these essential preventive office visits.

How are medications covered under the HDHP?

Under the HDHP plan, there is a difference between how "preventive" medications and all other medications are covered. Preventive prescription medications are subject to the three tier co-pay/coinsurance structure. If a covered medication is not on the preventive list, it is subject to the deductible and coinsurance; you will be required to pay the full cost of the medication until your deductible is met and 20% thereafter. You can find a list of preventive medications under the HDHP plan on the MPS mConnect site.

HDHP Out-Of-Pocket Maximum (OOP)

Unlike the other health plans, the HDHP has a combined prescription drug and medical Out-Of-Pocket maximum. All member deductible, coinsurance and co-pays for covered medical expenses and prescription drugs apply toward the Out-Of-Pocket maximum. Once the Out-Of-Pocket limit has been satisfied, there are no additional costs to the member for covered medical and prescription benefits in the calendar year.

How do I know which plan is best for me?

To evaluate which health plan is best for you, you need to be aware of what you currently spend for health care. Start by getting a picture of what you and the health plan spend on your health care by looking at your UHC account (myuhc.com) and your prescription drug costs or while logged into your myuhc.com account login, click on Manage My Prescriptions then click on Find & Price Drugs. Look at both what you and the plan pay toward the cost of care. Then take into account the full cost of each plan, including monthly premium costs, and the potential contribution to a HSA account for the HDHP. Then compare the savings from reduced premiums and evaluate whether the HDHP option might be best for you.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is an employee-owned bank-account that allows employees to save money in a tax advantaged account toward current and future medical expenses (and potentially save toward retirement).

What bank does MPS use for its HSA program?

MPS will open accounts for participating employees with Optum bank. You can learn more about HSA accounts and how to use them at: **https://www.optumbank.com/.**

Who owns the money in the HSA?

You own the HSA account. The HSA account is a personal bank account that MPS will open on your behalf with Optum Bank and pay the monthly account fee, while you remain an active employee and enrolled in the HDHP. At all times, you maintain ownership of, and responsibility for, the account. This includes the responsibility to only use the funds in the account for reimbursable medical, dental and prescription drug costs and the responsibility to manage the account to ensure that funds are not overdrawn. It is also your responsibility to adhere to the annual maximum contribution limits as determined by the IRS. Maximum contribution amounts for 2020 are $3,550 for individuals and $7,100 for families.

Will MPS contribute to my HSA?

Yes, if you are an active employee, you elect the HDHP plan during Open Enrollment and you are eligible to open a HSA account (see below), then MPS will provide a lump sum contribution in 2020 as follows: $400 for a single plan and $800 for a family plan into your HSA account. This employer contribution will be made for the 2020 calendar year participation in the HDHP for active employees only (neither a COBRA HDHP nor a retiree HDHP are eligible for this employer contribution). Sign up during Open Enrollment for enrollment in the HDHP effective January 1, 2020, and earn the employer contribution for calendar year 2020.

The HSA Account Authorization form (for new enrollments) and the HSA Annual Election Form 2020 must be completed and received in the Benefits office, room 124 at Central Services, on or before December 31, 2019 in order for an employee to receive the MPS employer contribution for 2020.

Please note: Employees who enroll mid-year or who experience a mid-year enrollment change will not receive a MPS employer contribution or a change in the MPS employer contribution level. You as the subscriber must be enrolled in the active HDHP option effective January 1, 2020, in order to receive the MPS employer contribution.

What can I use the money in my HSA for?

You can withdraw money from the account to pay for qualified medical expenses without paying any taxes. Qualified medical expenses include unreimbursed expenses for medical, dental, vision or prescription drug coverage for you and your qualifying dependents. These are explained in IRS Publication 502, Medical and Dental Expenses (http://www.irs.gov/publications/p502/). Remember with the HSA you need to substantiate that an expense is a qualifying expense, so save all your receipts. If the IRS asks, you must be able to show proof that the HSA money was used to pay or reimburse yourself for qualified medical expenses.

What happens if I withdraw the money to spend on non-qualified medical expenses?

If you withdraw funds to use on anything except qualified medical expenses, there is a 20% tax penalty that will apply. Once you reach the age of 65, you can withdraw funds without penalty, to use as retirement income, subject to normal income taxes.

What happens to funds left in the account at the end of the year?

At the end of the year, all funds in the HSA account remain in the account and are owned by the employee. Even if you are no longer enrolled in a qualified HDHP, you can continue to spend the money on qualifying medical expenses without penalty.

You can take the HSA with you if you change jobs or are no longer employed by MPS. Please note that you will be responsible for paying the monthly account fee when you are no longer enrolled in the MPS HDHP.

What are the tax advantages of a HSA?

MPS does not provide tax advice. However, there are tax benefits to owning and using a HSA account. The HSA has a "triple tax" advantage: (1) Employees can contribute to the account, via payroll deduction, on a pre-tax basis (or make post-tax contributions directly); (2) you pay no taxes on any interest or investment earnings; and (3) you pay no tax on funds withdrawn to pay eligible medical expenses. To learn more about how to use your HSA, visit: https://www.optumbank.com/product-services/health-savings-accounts.html or see IRS publication 969 (**http://www.irs.gov/publications/p969/index.html**) for further details, including federal tax treatment related to HSAs.

Can I change my contribution level during the year?

Yes. During the year, you can submit a new contribution form to the Office of Human Resources, Department of Benefits, Pension & Compensation, and stop, start or change the amount of your contribution deducted from your paycheck and deposited into your HSA account.

Please note: Your annual contribution election does not rollover into the next year – you must submit a new contribution form if you would like to contribute to your HSA for the new year.

Am I eligible to open a HSA account?

- You are eligible to open a HSA account if you are enrolled in the District's HDHP plan and:
- You are not covered by any other health coverage (unless that coverage is also through a qualified HDHP plan);
- You do not have a current Healthcare Flexible Spending Account (FSA). (If you wish to have a HSA account and receive the MPS contribution, you will be required to waive your right to any carry-over balance in your existing FSA account);
- You are not a dependent on anyone else's tax return; and
- You are not Medicare eligible

If, in future years, you are not eligible for a HSA account (e.g. because you are no longer enrolled in a qualified HDHP plan), you can continue to use the account to pay qualifying medical expenses, but you can no longer contribute to the account and the monthly account fee becomes your responsibility.

How do I enroll in the HSA programs?

If you elect to enroll in the High Deductible Health Plan (HDHP), you will be mailed an enrollment form for the HSA, which will include an authorization form to open the account and to elect any additional contribution that you may wish to make via payroll deduction.

OTHER BENEFITS (ACTIVE EMPLOYEES)

Dental

There are two dental plans offered to MPS employees: Delta Dental PPO and Delta Dental EPO. These plans are only available to active employees.

Delta Dental PPO coverage provides in and out-of-network benefits for an array of dental services. When you use an in-network Delta Dental provider, you and the district save money because network providers have agreed to lower negotiated fees.

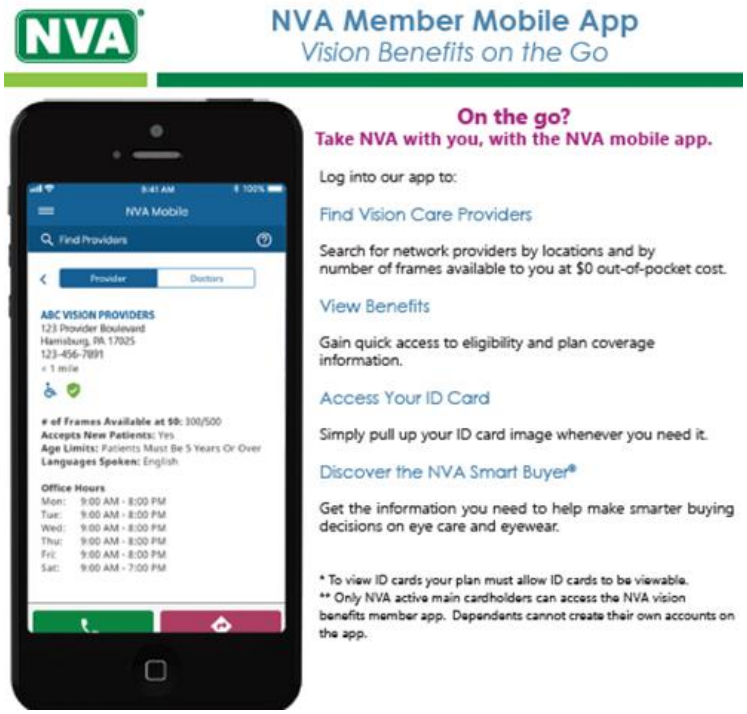
Delta Dental EPO coverage provides in-network coverage for covered dental services. Members may still use providers at one of the multiple Dental Associates facilities or see other in-network providers for services covered under this MPS Delta Dental EPO plan. The Delta Dental EPO plan only provides coverage for services from a Delta Dental PPO provider.

To find an in-network dentist go to: www.deltadentalwi.com, select "Find A Dental Provider" and search for a provider in the network entitled "Delta Dental PPO," or call 1-800-236-3712. Please see the dental coverage comparison chart Appendix B: Dental/Vision section of this booklet (page 51).

NOTE: Retirees are not eligible to enroll in a dental plan. Retirees currently enrolled in COBRA dental and who are paying for this COBRA continuation coverage will be mailed Open Enrollment materials under separate cover.

Vision

If you are an active employee and enrolled in a MPS health plan, you will also be automatically enrolled in and receive routine vision coverage through National Vision Administrators (NVA). This routine vision coverage is an in-network benefit only, so you must see a NVA provider to receive coverage. When enrolled, NVA will provide you with an identification card. For a list of network providers, please visit **www.e-nva.com.** **Note:** Vision benefits are not offered on a free standing basis (e.g. can't be unbundled from the health plan) and retirees are not eligible for this vision coverage through NVA. For coverage details please see Appendix B: Dental/Vision (page 52).



Health Plan Opt-Out

In order to be eligible for the Opt-Out Option, eligible employees must provide (1) Annual Verification of current health coverage under another employer group health plan and
(2) Attestation of you and your tax family's (as defined by the IRS go to https://www.irs.gov/pub/irs-pdf/p501.pdf) having Minimum Essential Coverage (MEC) as defined by the Affordable Care Act (ACA). For more information about tax family/dependents go to www.irs.gov/uac/who-can-i-claim-as-a-dependent. For more information regarding MEC go to www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-minimum-essential-coverage. **Opt-Out payments will not automatically roll over from year to year. All employees that are currently enrolled in this benefit as well as employees enrolling in the Opt-Out plan for the first time must provide the required documentation.**

NOTE: A limitation of the Opt-Out plan includes employees who are covered as a dependent under an MPS health plan and submit another employer plan as coverage – these employees are not eligible for the MPS Opt-Out option while covered under an MPS health plan.

Who is eligible?

Any MPS employee eligible for health insurance coverage (except Board Members and Retirees) is eligible for opt-out if he/she elects not to subscribe to an MPS health plan due to having coverage under a non-MPS health plan. If you are canceling your current MPS health coverage enrollment, you must be covered by another employer's health insurance plan (generally you will be a dependent or spouse covered under a non-MPS health plan). In lieu of taking MPS health insurance coverage, you are eligible for a $50 per month taxable payment up to $500 in calendar year 2020.

How do I apply for the Opt-Out payments?

To enroll you must provide the following:

- Upon hire or a family status change, complete an MPS Application/Change form electing the Opt-Out Option.
- During open enrollment, use the Open Enrollment Benefits Application form.
- Submit Annual Verification of other health coverage in the form of a statement on an employer's letterhead certifying you are covered under that employer's health plan or a HIPAA certificate of coverage is acceptable. Other health coverage does not include coverage in the individual market, whether or not obtained through the Marketplace, or enrollment in a government plan such as Badger Care, the VA or Tricare. Also, a copy of an ID card is NOT considered proof of coverage.
- A completed "Payment in Lieu of Health Coverage" form which includes your attestation of your tax family/dependents having MEC coverage. A Payment in Lieu of Health Coverage form can be obtained at MPS Department of Benefits, Pension & Compensation, 5225 West Vliet Street, Room 124.

When do payments begin?

- Payments are $50 per month, over 10 months in a calendar year, on the second check of the month per your pay calendar.
- If you are newly eligible, payments will begin with the month health coverage would have started had you applied.

- If you elect this option during open enrollment, payments of $50 per month will begin with the second paycheck of January.

What if my non-MPS health coverage cancels?
In the event your other coverage is canceled at a time other than open enrollment, you may enroll in the MPS group health plan coverage if you submit an application along with proof of loss (COBRA forms, HIPAA coverage certificate, and statement on employer letterhead are acceptable) to MPS Department of Benefits, Pension & Compensation within 31 calendar days of your loss of coverage. Upon receipt of this application and proof of loss within the time limits, your MPS group health plan coverage will begin when your other insurance lapses, without being subject to waiting periods or the exclusion of pre-existing conditions. Voluntary cancellation of the other insurance does not allow you to enroll unless the voluntary cancellation was a result of an increase in the required employee premium payment or a decrease in benefits under that plan.

What if I go on an unpaid leave of absence?
Your Opt-Out Option will terminate as soon as you have no active pay. If you are on FMLA, your coverage will automatically be reinstated once you return to work. For any non-FMLA leave, you will need to re-enroll and provide proof of other coverage once you return to work.

What if I have further questions?
If you have further questions concerning this program or need the Payment in Lieu of Health Coverage form, please contact MPS Department of Benefits, Pension & Compensation at (414) 475-8158 for last names starting with A-G, (414) 475-8233 for last names starting with H-O or, (414) 475-8215 for last names starting with P-Z.

Life & Disability Insurance

Please note: The Open Enrollment period does not apply to the life and disability benefits. Below are highlights of the life and disability plans. For more detailed information please visit The Standard's website https://standard.benselect.com.

Additional Life Insurance (Employee-paid premium once per month):

- Rates for Additional Life Insurance for yourself and your spouse are based on an age-band rate table, and rates have changed effective January 1, 2020. Please be aware that the change to the rate table may increase the cost of your additional life insurance in 2020, even if you make no changes for next year.
- **Annual Enrollment**: During Annual Enrollment you may elect to increase your Additional Life Insurance by one $10,000 increment, not to exceed the Guaranteed Issue Amount (see chart below). If your increase exceeds the Guaranteed Issue Amount you will have to submit evidence of insurability in order for it to be approved. **This Annual Enrollment period will be from October 21 through November 8, 2019, and will be effective on January 1, 2020.**
  - You can find more detailed information and apply for Additional Life Insurance on The Standard's website https://standard.benselect.com**. For security purposes all usernames and passwords have been reset to use your six-digit employee ID as your username and the last 4 digits of your Social Security Number plus the last two digits of your birth year as your PIN.**

	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
Employee	$10,000	$10,000	$250,000	$500,000*
Spouse	$5,000	$5,000	$50,000	$250,000
Child	$5000	$5,000		$10,000

***Not to exceed 5 times your Annual Earnings**

- **Late applications for Additional Life Insurance (applying 31 days after first initial eligibility):** All late applications, requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- **Family Status Change:** If you have a Family Status Change, you may elect new coverage or increase your coverage for you or your spouse, not to exceed the Guarantee Issue Amount, without submitting Evidence of Insurability if you apply within 31 days of a Family Status Change (see Family Status Changes/Life Events chart on pages 55-57 for more information).
  - To elect additional life insurance coverage due to a Family Status Change, submit your request in writing (signature needed) to MPSemployeebenefits@milwaukee.k12.wi.us. Questions? Please contact The Standard onsite account specialist at 414-475-8699.
- The coverage amount for your spouse cannot exceed 50 percent of your Additional Life coverage

- The coverage amount for your child(ren) can be elected for either $5,000 or $10,000 and cannot exceed 50 percent of your Additional Life coverage
  - The child life insurance coverage is from live birth through age 25. At your child's attainment of age 26, if you are only insuring one child, you will need to contact The Standard onsite account specialist at 414-475-8699 or email: MPSemployeebenefits@milwaukee.k12.wi.us to terminate this coverage.

Voluntary Long Term Disability (Employee-paid premium once per month):

- **Current Participants**: If you are currently participating in the LTD Insurance, your enrollment will continue for 2020- you will not have to re-enroll.
- **Late application for Long Term Disability:**
  All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior LTD insurance plan are also subject to medical underwriting approval.
  - You can apply for LTD on The Standard's website https://standard.benselect.com; see login information under Additional Life Insurance.
  - On the Standard website you will see:
    1. Coverage highlights
    2. The LTD options available
    3. Your monthly cost

Voluntary Short Term Disability (STD) (Employee-paid premium once per month):

- Short Term Disability (STD) for Class 2 "regular employees other than the Superintendent, Cabinet or Exempt Administrators & Supervisors" have a rate change to their STD benefit effective January 1, 2020. The new 2020 rate for STD coverage for Class 2 is $0.820 per $10 of benefit. Please see this new STD Class 2 rate by logging in to The Standard's website https://standard.benselect.com; see login information under Additional Life Insurance on the previous page. Please be aware that this STD Class 2 rate change will increase the cost of your STD coverage for Class 2 employees in 2020. This STD rate for Class 2 employees is guaranteed through December 31, 2022.
- **Current Participants:** If you are currently participating in the STD Insurance, your enrollment will continue for 2020- you will not have to re-enroll.
- **Late application for Short Term Disability:**
  - If you do not apply for this STD coverage within 31 days of first becoming eligible, were eligible for insurance under the Prior Plan for more than 31 days but were not insured, or if your insurance ends because you failed to make a required premium contribution and is later reinstated, your benefit waiting period for physical disease, pregnancy or mental disorder will be 60 days if you become disabled during the first 12 months after your coverage takes effect.
  - You can apply for STD on The Standard's website https://standard.benselect.com; see login information under Additional Life Insurance.

Employer-Paid Group Life Insurance:

All employees scheduled for 30 or more hours in a benefit-eligible position are covered under MPS's employer-paid Group Basic Life Insurance and AD&D. For more information see the Summary of Benefits in the MPS website, or The Standard's website at https://standard.benselect.com.

The amount of Group Basic Life coverage is 1 times your annual earnings, rounded up to the next $1,000, to a maximum of $200,000. **Please note:** The value of the premium payment in excess of a $50,000 benefit coverage level is subject to federal income tax when the Board pays 100% of coverage in excess of $50,000.

Your Group Basic Life Insurance includes Travel Assistance and the Life Services Toolkit (includes free services for creating a simple will, living will, and a power of attorney). See more information on mConnect > Department of Benefits & Compensation.

Online Beneficiary Designation: Visit https://standard.benselect.com to update your life insurance beneficiaries. **Paper-based beneficiary designations will not be transferred.** See login information under Long Term Disability.

To terminate/cancel additional life and disability coverage during annual enrollment (10/21/2019-11/08/2019) submit your request in writing to MPSemployeebenefits@milwaukee.k12.wi.us. Changes will be effective January 1, 2020.

Termination of additional life or disability coverage: If you wish to terminate/cancel your additional life insurance and/or disability coverage, you can submit a written request to: MPSemployeebenefits@milwaukee.k12.wi.us. Coverage termination and cancellation requests will be effective first of the following month and will not be retroactive.

Questions? Please call The Standard's onsite account specialist at 414-475-8699.

Wellness Program

Milwaukee Public Schools offers a robust employee wellness benefit that includes a number of different programs, resources, and support at no cost to you. It is our mission to help MPS employees thrive both personally and professionally by providing the resources and support needed in order to live well. Please see the descriptions of each individual benefit below. Eligibility & enrollment processes may vary.

HEALTHY YOU
HEALTHY SCHOOLS
Professional | Physical | Emotional

Healthy Contributions (Gym Reimbursement):

A $20 gym membership reimbursement provided to you by MPS and our vendor, Healthy Contributions. Eligible employees and spouses who attend an in-network fitness facility and meet the minimum attendance requirement of 10 visits per month can each earn a reimbursement of up to $20 per month. The reimbursement will be added to the employee's second paycheck of each month.

Eligibility:

To be eligible for the Healthy Contributions reimbursement you must:

- Be an **active employee (non-retiree)** and on an MPS health insurance plan.
    - If for any reason you become inactive on the health insurance (i.e. leave of absence), you and your spouse will **not** be eligible for reimbursement.
- Be the spouse of an active employee (non-retiree) on the MPS health insurance plan.
    - If for any reason the employee becomes inactive on the health insurance (i.e. leave of absence), the employee and the spouse will **not** be eligible for reimbursement.
- Belong to an "in-network" fitness facility. In-network facilities are listed on the Healthy Contributions page on mConnect.
- Attend the fitness facility a minimum of 10 times per month (from the first of the month to the end of the month).

Enrollment:

- Print out an Enrollment Form from mConnect and take it to your fitness facility. The gym will enroll you. If they have any issues, have them call Healthy Contributions at 1-800-317-2739. This number is on the bottom of your enrollment form.
- If both and employee **and** a spouse are enrolling, both parties must fill out *separate* enrollment forms.
- If a spouse is enrolling, they must have the employee ID number and the signature of the MPS employee. If those fields are left incomplete, registration will not be completed.
- Both employee and spouse should understand that reimbursements will be added to the check of the employee that is the primary insurance carrier with MPS. Reimbursements will be added to the employee's second paycheck of each month.
- Enrollment in this program is on-going. Employees and spouses may enroll at separate fitness facilities.

Policies:

Healthy Contributions is a ***reimbursement*** program, which means:

- The employee is responsible for all upfront costs entailed in the gym membership.
- The employee is responsible for any remaining costs of the membership outside of the $20 reimbursement or in the event that the reimbursement is not earned.
- Reimbursements are retroactive, meaning that the employee must be prepared to bare the total cost of the monthly membership fee and earn the reimbursement at a later date. Example: Tracked visits in November will be reimbursed at the end of December.

- If you have a spouse receiving reimbursements and they are not an MPS employee, their funds will also be processed through MPS payroll with the appropriate taxes deducted on your paycheck.
- If you and your spouse are MPS employees, the reimbursement will go on the payroll check of the employee that is the primary health insurance carrier with MPS.

Gyms in Network:

- Most gyms in the Milwaukee area do participate in this program. For a comprehensive list, please go to the Healthy Contributions page on mConnect.
- If you belong to a fitness facility that is not currently a Healthy Contributions partner, we would gladly welcome them! Go to the Healthy Contributions page on mConnect and print the "Nomination Flyer" and take it to your gym. The Nomination Flyer will provide Healthy Contributions contact information to help begin facilitation of that new partnership.

Frequently Asked Questions:

I didn't receive my reimbursement.

Each month your fitness facility must submit your recorded number of visits through the reporting system provided by Healthy Contributions. It is possible for a visit report to show incorrect visit data, resulting in a missed reimbursement for you. In this case, you must confirm the correct number of visits with the fitness facility and ask them to **resubmit** the correct data on the following month's report. Call your gym and ask to speak with the employee that administers the Healthy Contributions program.

How can I check the visits reported for me in any given month?

You can either call your fitness facility or call Healthy Contributions directly at 1-800-317-2739 (or email at info@healthycontributions.com).

UnitedHealthcare Tobacco Cessation Coverage

If you have UHC insurance through MPS, your coverage does include certain tobacco cessation aids. Below are a list of the prescription drugs and over-the-counter (OTC) drugs covered at no cost. Quantity Limits may apply. In order to receive the medication at no cost, you must get a prescription from your doctor (even if they are over-the-counter medications)! Please visit OptumRx through the UHC website by logging in at myuhc.com for more details.

Over-the-Counter Medications include:

- Nicotine Replacement Therapies: Nicotine TD Patch - 7, 14, 21mg/24 HR, Nicorette Gum - 2mg, 4mg, or Nicorette Lozenge - 2mg, 4mg; Nicotrol Inhaler or Nasal Spray
- Zyban 150mg/12 HR Tablets
- Chantix: 0.5mg, 1mg, and Titration/Starter Pak

Stress & Emotional Well-being

Employee Assistance Program:

Commonly referred to as "EAP", MPS' employee assistance program is here to help you sort through all of life's challenges. Get in touch with EAP by calling 1-800-236-3231 now! The line is open 24/7.
Services provided include but are not limited to:

1. Counseling
    - Typical concerns include workplace stressors, relationship issues, anxiety/depression, divorce, financial pressure, child/family concerns, legal issues, caring for aging parents, and more.
    - Services provided either over the phone or in person - your choice!
    - Three (3) free counseling sessions are provided. If continued care is necessary, the EAP counselor will work with you directly to find a more permanent solution in coordination with your health coverage.
2. Service Referrals/Consultations
    - Typical services include elder care, child care, legal consultation/mediation, financial consultation, and adoption services.

Wellness On-Site

Wellness On-Site is a menu of physical, emotional, and professional wellness programming offered on site, at your work location, and at no cost to you! Wellness On-Site provides a myriad of opportunities to bring engaging, healthy, and fun wellness programs on site to your school/department. Get together with co-workers to de-stress, learn, and work together as a team. Choose from over 100 different wellness programs!

Each school/work site has an annual budget of $1,000 allocated in their name to spend on wellness programs in the menu. The program menu can be found on the "Wellness On-Site" page on mConnect.

In order to participate, each work site must designate a voluntary 'Wellness Champion' who serves as the site based coordinator for this program. Wellness Champions will be responsible for surveying co-workers to gauge interests, selecting and registering for programs, and then coordinating with the vendor service providers directly on any details. Details about being a Wellness Champion can be found on the "Wellness Champion Resources" page on mConnect.

Registration for Wellness On-Site programs is on-going. Wellness On-Site can provide on-site group exercise programs (Yoga, Zumba, cardio classes, etc), weight loss team challenges, adult sport leagues, mindfulness based stress reduction, team building, professional development, self-defense, art therapy, and more! Participation in this program is voluntary; however, programs can be scheduled during non-student time with principal/supervisor approval.

ENROLLMENT PROCEDURES

We welcome you to deliver your completed form(s) in person! It is your responsibility to have your completed enrollment form(s) in our office (Rm. 124 in Central Services) by the deadline of 5:00 p.m. on Friday, November 8, 2019.

Am I required to submit an application?

You must complete the enclosed Open Enrollment (OE) application if:

- you are enrolling for the first time,
- you wish to change your present health/vision or dental plan,
- you are changing dependent(s) covered under those plans, adding or removing dependents or
- you are updating/correcting information on the form. OE changes are effective January 1, 2020. **If you do not return an enrollment form, MPS will continue your current eligible coverage.**

How do I enroll in my chosen plan?

1. Use the enrollment application enclosed with this booklet, which contains your individual information. If you lose the enclosed form, it takes time to make another form for you. Employees who complete the enclosed form get higher service priority. WE DO NOT RECOMMEND SENDING CONFIDENTIAL INFORMATION VIA INTEROFFICE MAIL.
2. We suggest that you bring your original form(s) along with a copy to the MPS Department of Benefits, Pension & Compensation, Room 124. We will date and time stamp the copy for you so that you have it as a "receipt" for your records.
3. If you do not return your form(s) in person to the MPS Department of Benefits, Pension & Compensation office, keep a copy for your records and send the original form to Milwaukee Public Schools, Office of Human Resources, Department of Benefits, Pension & Compensation, 5225 West Vliet Street, Room 124, Milwaukee, Wisconsin, 53208.
4. **Please note:** If you are adding a dependent, you are required to submit verification (birth certificate or marriage certificate).

What if my spouse is a MPS employee?

Where both spouses are employed by or retired from MPS, MPS will pay either a single plan for each **or** one family plan for both. Please indicate the MPS Employee ID# (six digits) of your spouse if completing an OE application.

Enrollment Changes outside of Open Enrollment (Family Status Changes)

When can I make changes (add dependents, drop coverage/dependents or add coverage) outside of the Open Enrollment Period?

After Open Enrollment, additions, terminations, and changes will only be allowed to your MPS health/vision and dental plans as the result of a family status change – please see pages 55-57 for a list of allowable Family Status Changes/Life Events with more detailed information. In order to enroll in coverage or add new dependents to your MPS health/vision and dental plans, you must file a new, complete application with MPS Department of Benefits, Pension & Compensation within:
31 calendar days of a qualifying family status change event, 60 calendar days for birth, adoption, or loss of Medicaid or State Children's Health Insurance Plan (CHIP).

Family Status Change	Copy of Document or Notice Required
Marriage	Marriage Certificate (Must be registered certified state copy. Testament of marriage is not valid proof.)
Birth	Birth certificate or proof that the birth certificate is registered.
Adoption	Court adoption or adoption agency placement letter.
Divorce	Notification of date of divorce.
Death	Notification of date of death.
Loss of Other Insurance Coverage	HIPAA notice of coverage loss.

Remember you are required to report other insurance changes and loss of dependent status for spouse and/or children immediately to MPS Department of Benefits, Pension & Compensation throughout the year as they occur. Do not miss these deadlines to report this important information.

What documentation is required to enroll a new dependent or initiate an enrollment change based on a change of family status?

The chart above and on pages 55-57 is a list of the most common family status changes and the documentation needed from you to make a change.

Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation will delay processing of your eligible dependent(s). If verification is not received within 31 calendar days of our written request, the dependent will not be enrolled and will have to wait until the next Open Enrollment period to enroll.

HOW DO I COMPLETE THE OPEN ENROLLMENT APPLICATION?

Instructions

Please complete the 2020 Open Enrollment Benefits Application Form if you are making a change to your current coverage, enrolling for the first time, or updating your coverage information.

Complete the 2020 Open Enrollment Benefits Application Form by selecting the coverage option (single or family) for health/vision and/or dental insurance. Please note the following:

- You cannot elect vision only coverage. The only vision provider is National Vision Administrators (NVA). If you are electing health coverage, you are automatically enrolled in vision coverage (except retirees).
- If you enroll in single coverage for health/vision and/or dental, please verify information on the application form for yourself (subscriber).
- If you enroll in family coverage for either health/vision or dental or want to correct any of the information provided about your dependents, please complete/correct the Dependent(s) section of the application form for all eligible dependents in addition to yourself and your spouse, if applicable. Please indicate "yes" if you want to enroll your dependents in health or dental coverage or "no" if you do not want to enroll your dependent(s) in health or dental coverage. If deleting a dependent, please provide reason for deletion and event date (see application).

- Only eligible dependents will be accepted. Please refer to the Dependent Eligibility Rules section beginning on page 15 of this booklet for detailed information on eligible dependents. Additional information may be requested to verify a dependent's eligibility. **COVERAGE WILL NOT BE EFFECTIVE FOR ANY DEPENDENTS YOU DO NOT INCLUDE ON THE APPLICATION FORM.**
- If you are enrolling dependents other than your spouse, the following is a list of valid options for the Dependent Relationship section: Natural or Adopted Child, Grandchild (must meet requirements on page 15), Legal Ward/Guardian (documentation of such status is required if it has not already been provided), and Stepchild.
    1. If you have a **disabled dependent**, please indicate yes on the application form and whether the dependent is Medicare eligible. Additional information may be requested to verify the disabled status of the dependent.
    2. IF YOU ARE ENROLLING ANY DEPENDENT(S) YOU MUST SUBMIT VERIFICATION OF DEPENDENT ELIGIBILITY. For example, if you are enrolling a spouse and/or dependent child(ren), you must submit a marriage certificate and/or birth certificate(s). Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation can delay or possibly prevent the enrollment of your eligible dependents.
    3. If you are making changes or corrections, please retain a copy of the application for your records. We encourage you to return your original application form in person to MPS Department of Benefits, Pension & Compensation at the address listed below. Bring a copy of the application form with you and we will date and time stamp the copy as received for your records.
    4. If you do not return your form to MPS Department of Benefits, Pension & Compensation in person, please mail the original Open Enrollment Application Form to Milwaukee Public Schools, Office of Human Resources, Department of Benefits, Pension & Compensation, 5225 West Vliet Street, Room 124, Milwaukee, WI, 53208.

Terms and Conditions of Submitting Applications

By completing the MPS Open Enrollment Benefits Application form, you are agreeing to the following terms and conditions:

1. I hereby apply for enrollment/plan membership for the person(s) listed and agree that my dependents and I shall abide by the provisions of coverage in the service agreement under which we are enrolled.
2. I understand enrollment is subject to all of the terms and conditions on the Master Group Policyholder Agreement with the provider I have chosen.
3. I hereby authorize deductions from my earnings of the required contributions toward the cost of the monthly premium as required by the terms and conditions of employment.
4. I consent and authorize any physician, dentist, consultant, hospital or other person by whom any diagnosis, medical, surgical, dental treatment or advice has been rendered to release pertinent medical, surgical, dental reports and records as requested to the insurance plan I selected subject to all applicable provisions of the Health Insurance Portability and Accountability Act of 1996.
5. I understand that coverage is effective only upon timely submission of a complete application to MPS.
6. I certify that the application information is complete, true, and correct subject to State, Federal and Board policy insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependent(s). MPS reserves the right to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. I have shared the "General Notice of COBRA Continuation Coverage Rights" with all eligible family members. As information requested on this form changes, I understand I must promptly inform MPS Department of Benefits, Pension & Compensation in writing within 31 calendar days of a Qualifying Family Status Change or 60 calendar days for birth/adoption or loss of Medicaid or CHIP. Please refer to DEPENDENT ELIGIBILITY RULES below for additional details. Failure to provide such written notice may result in loss of coverage or denial of benefits.
7. MPS reserves the right to determine eligibility and obtain all necessary information to verify eligibility. MPS also retains the right to conduct periodic audits, including random audits for eligibility verification.

DEPENDENT ELIGIBILITY RULES

When enrolling any dependent(s), you must submit verification of dependent eligibility. For example, if you are enrolling a spouse you must submit a marriage certificate or if you are enrolling a dependent child(ren) you must submit a birth certificate(s). Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation may delay or prevent processing of your eligible dependents. As per Board policy and Plan provisions, the following dependents are eligible for coverage:

- Spouse is the person to whom the subscriber is legally married.
- Dependent Child includes the following:
    - Natural or adopted child of the subscriber.
    - Stepchild - is the natural or adopted child of the subscriber's spouse for whom the subscriber and/or spouse provide more than 50% of the child's support during a calendar year.
    - Legal Ward - is a child for whom the subscriber or current spouse is the legal guardian and for whom the subscriber and/or spouse provide more than 50% of the child's support during a calendar year.
    - Grandchild - is a child of the subscriber's dependent child for whom the subscriber and/or spouse provide more than 50% of the grandchild's support during a calendar year when the grandchild's parent is under age 18.
- Adult Child Dependent Eligibility – As a result of State and Federal mandated changes* to health and dental coverage, adult dependent children (age 19 and older) must meet coverage eligibility as outlined below. These mandates **do not require you** to cover your adult children under your MPS health and/or dental plan.
    - Adult child is between the ages 19 to 26.
    - Adult child can be single or married.
    - Per State mandate, eligibility requirements also include the adult child who is a full-time student regardless of age **and** was under age 27 years when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.
    - Application for disabled dependents continuation of health and dental coverage must be completed prior to turning age 26.

    *****WI Statute 632.885; Federal Acts PPACA and HCERA

Removing Ineligible Dependents from Your MPS Health and/or Dental Plan

You are required to notify MPS Department of Benefits, Pension & Compensation of events such as a divorce or death of spouse in order to remove ineligible dependents from your plan. In the case of divorce, your ex-spouse and your step-child(ren) from that marriage are no longer eligible to be covered as your dependents and you must remove them from your MPS health and dental plan within 31 calendar days. MPS reserves its right to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud.

Where Both Spouses Are Employed by MPS

Where both legally married spouses are employed by MPS, only a single plan for each or one family plan for both are permitted. An employee who changes marital status, or acquires dependents must apply by filing a new, complete application listing all covered dependents with MPS Department of Benefits, Pension & Compensation within 31 calendar days of the event (60 calendar days for birth or adoption, loss of Medicaid or CHIP coverage) in order for such coverage to be effective as of the date of the event.

Note: Employees shall not be entitled to duplicate coverage under any other health, prescription, dental or vision insurance plan offered by the Board.

When Health and Dental Coverage Ends

Board paid health and dental coverage for the employee and all dependents ends on the last day of the month following the month in which the employee becomes ineligible due to non-payment of the required employee premium contribution, termination, suspension, resignation, layoff, move into a non-benefit eligible position, or unpaid status for more than one-half the number of paid work days in a calendar month. However, for Regular/Traditional and Early Start School Calendar employees

who lose eligibility at the end of their regularly scheduled school year, health and dental coverage ends on August 31 following the loss of eligibility.

As per Board policy/procedures, Plan provisions, and State/Federal mandates, coverage ends for dependents as follows:

- Spouse - coverage ends at the end of the month in which the spouse is no longer legally married to the subscriber.
- Dependent Child - End of the month in which adult child attains age 26 per current State and Federal mandates in effect as of the date of this publication. Note: See page 15 Adult Child Dependent Eligibility for additional details.
    - Health/Vision and Delta Dental Plans effective January 1, 2020 - coverage ends at the end of the month in which the child attains age 26, regardless of support, unless prior to attaining age 26 the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the subscriber and/or subscriber's spouse for support and maintenance. Proof of such incapacity and dependency must be furnished by the subscriber to the employee's health plan, at no expense to the employee's health plan, within 31 calendar days of the child's attainment of age 26, and subsequently when and as often as the employee's health plan may reasonably require but not more frequently than annually after the two-year period following the child's attainment of age 26.
- Grandchild - coverage ends at the end of the month when the grandchild's parent loses dependent status or the grandchild's parent turns 18 or the subscriber and/or spouse no longer provide more than 50% of the grandchild's support.
- Loss of legal status - coverage ends at the end of the month in which the child no longer meets the definition of stepchild or legal ward. For example, a stepchild's parent is no longer legally married to the subscriber; legal ward's coverage ends at age 18.
- Emancipation - coverage ends at the end of the month in which the child is legally emancipated, even if the emancipation occurs prior to the attainment of age 19.

In the event you, your spouse or your dependent children lose Board health and/or dental insurance coverage due to a loss of employment for any reason (except gross misconduct), divorce, death of a spouse, over-age dependent child, or move into a non-benefit eligible position, you and/or your spouse and dependent children are eligible to remain in the group on a self-pay basis for either 18 or 36 months. For more information about COBRA continuation, see section under Mandatory Notices in this booklet.

FREQUENTLY ASKED QUESTIONS

What is a deductible?

A deductible is a flat-dollar amount you pay annually, on a calendar year basis, before coinsurance benefits are payable. If you are enrolled in a family EPO or PPO plan, the deductible can be met by one individual at a time or you pay up to three individual deductibles to meet your maximum family deductible for the calendar year. Under the HDHP, the family coverage deductible is an aggregate total that applies to all individuals covered by the plan. See: "How does the HDHP deductible work?" on page 4. Under the UnitedHealthcare PPO plan and under the HDHP, in-network and out-of-network deductibles ARE NOT cross-applied.

Do I have to pay the deductible up front before my insurance pays anything?

In general, when a plan has a deductible and coinsurance, the providers will bill the third party administrator (UnitedHealthcare) first to determine what contractually will be paid under the plan. Then the provider will bill you for the amounts not paid by the administrator, which should be the deductible and coinsurance amounts. Look for your Explanation of Benefits (EOB) statements from UnitedHealthcare to confirm that your calendar year deductible and coinsurance have been applied and they agree with what the provider is billing you.

To whom do I pay the deductible?

You pay the deductible or coinsurance under the plans to the provider directly. This may be requested by the provider up-front (at the time the services are rendered) or the provider will bill you for these amounts not payable by the administrator (UnitedHealthcare). Remember, any covered amount applied to your deductible is your responsibility and you will need to pay the appropriate provider.

Do I need to find an in-network hospital when I have an emergency?
The Emergency Room (ER) is for treatment of life-threatening or very serious conditions that require immediate medical attention and your MPS health plan provides an Emergency Room benefit for your care, whether the hospital is in-network or out-of-network.

I don't understand when I should pay the co-pay versus the coinsurance, what is the difference between the two?
Co-pays are typically a flat dollar amount (but can be a percentage amount) that you pay each time you use the service and the plan pays the balance for that service. EXAMPLE: for a hospital emergency room service, the PPO plan pays 100% after you pay the $150 co-pay. For an in-network non-surgical specialist office visit the PPO plan pays 100% after you pay the $35 co-pay. Please note, however, that in the case of a physician (non-specialist) visit, which is a flat co-pay of $20, if you have additional services like lab work (i.e. blood draw), diagnostic or x-ray services, these additional services are subject to the deductible and coinsurance up to your annual limit.

After the deductible is met each year, the plan pays a percentage of most covered expenses and you pay a percentage. This percentage is your coinsurance. Please note that the percentage paid by the plan for in-network services is greater than the percentage paid for out-of-network services, giving you an incentive to use in-network providers since your coinsurance will be less. EXAMPLE: assuming you have satisfied the applicable deductible under the MPS PPO plan, for an in-network $200 lab charge the plan would pay 80% or $160 dollars and you would pay a 20% coinsurance of $40.

How does UnitedHealthcare determine calendar year benefit maximums for a plan year?
Calendar year benefit maximums are payment limits applied to specific covered medical services that are incurred during the plan year, which is January 1 through December 31 each year. Once a specific calendar year maximum limit has been reached by a covered member under the plan, no more benefits will be payable by that plan for that particular service for the remainder of the calendar year. These maximums can be stated as day, dollar or visit limits depending on the covered service and are standard under most health care plans including the MPS plans.

Covered services are tracked by each individual member under the same subscriber record for the calendar year, even if the plan type changes at any time during the calendar year. EXAMPLE: if a member moves from active status to continuation coverage under COBRA, the benefit usage remains with the individual and continues to be applied to the benefit limit for the remainder of that calendar year. For instance, if a member used 14 of the 20 physical therapy visits from January through April of a given year, and then continues under COBRA on May 1, that member would have 6 visits remaining before they reached the benefit maximum for that calendar year.

What if my spouse is also employed by MPS and I want to switch to his/her plan?
If you change subscriber records during the calendar year, any deductible, coinsurance and covered services limits met in the calendar year do not transfer with the individual. For example, a spouse to spouse transfer during the year where the dependents are now covered under another subscriber record will not have deductible, coinsurance and covered services transferred with them – new deductible and coinsurance maximums will need to be met for the remainder of the calendar year for every family member covered under the spouse to spouse transfer.

Remember, services need to meet all plan provisions including medical necessity – a specific dollar or visit limit stated for a benefit is not a guarantee of coverage up to that limit. UnitedHealthcare regularly reviews claims in accordance with plan provisions prior to benefit limits being met. As always, if in doubt, your healthcare provider can review the plan's coverage limitations including calendar year benefit maximums and pre-authorize such services.

I am just returning from an unpaid leave and my health and dental benefits have terminated. How do I get my benefits reinstated?
If you do not continue your benefits while on an unpaid leave of absence by self-paying the applicable premium, your medical/vision and dental insurance will remain terminated until you return to work and you must re-enroll for coverage. **Your medical/vision and dental coverage is NOT automatically reinstated.** You must submit a completed Benefits Application/Change form within 31 days of your return to work or you must wait until the next Open Enrollment period (currently scheduled in the Fall with coverage effective January 1st) to enroll. Your effective date of coverage is subject to the same eligibility rules that apply to a new employee, i.e. coverage will begin the first of the month following 31 days of the date you return to work, provide you re-enroll.

Note: If you are enrolled in the Opt-Out Option and return from an unpaid leave of absence that is not FMLA, you will need to re-enroll and provide proof of other coverage once you return to work.

How does electronic coordination of benefits (eCOB) work for pharmacy benefits provided by OptumRx in 2020?

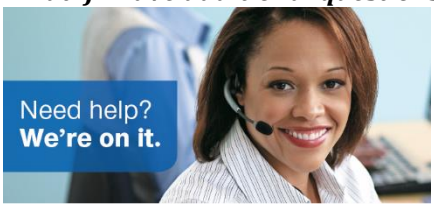
If the MPS OptumRx Plan is secondary coverage for prescription drugs because you and any of your covered dependents also have other insurance covering prescription drugs, coordination of benefits is available electronically (eCOB) at retail, in-network OptumRx pharmacies. This means that your prescription drug claims can be submitted easily, automatically and without the claim submission paperwork to OptumRx for secondary payment reimbursement.

To take advantage of eCOB, you must use an in-network pharmacy set up for electronic claims submission. To find out whether your pharmacy can submit electronic claims, just ask the pharmacist. If the pharmacy is equipped for electronic claims submission, simply show both the primary insurance coverage identification card and your MPS Heath/OptumRx card. Your claim will be processed electronically on the spot with both plans paying their respective share of your claim. You then pay only your Out-Of-Pocket costs for every prescription at the time of purchase.

Please note that if an OptumRx network pharmacy is not equipped to submit electronic COB claims, you must continue to submit paper claims to OptumRx for reimbursement of your covered Out-Of-Pocket expenses. Also, if your covered dependents' primary plan requires full payment, you must make that payment and submit a paper claim for reimbursement, first to the primary insurance, then to OptumRx.

To avoid disruption of coverage using eCOB, remember to update UnitedHealthcare with changes to your other insurance coverage, at any time throughout the year, for you or your covered dependents under a MPS plan. You may contact UnitedHealthcare for the EPO, PPO, or HDHP at 1-877-440-5982.

What if I have additional questions?



Contact UnitedHealthcare Advocate4Me: Monday- Friday 7 a.m. to 10 p.m. at 1-877-440-5982. Or log on to www.myuhc.com®, select "Help" at the top or bottom of the screen, and then select "We'll Call You" or "Chat Now."

We're here to help make things simpler for you.

We know that managing your health plan benefits and your health isn't always easy. That's why we have a team of people dedicated to helping you. From understanding your claims to estimating costs ahead of time, we're here to help. You may want to know:

- Is this treatment covered?
- How much will I have to pay for a test my doctor wants me to get?
- What does this charge mean on my bill? And why is it this amount?
- Can you help explain my benefits and what I need to do?
- If I need to find a new doctor, can you help me?

UnitedHealthcare®

MANDATORY NOTICES

General Notice of COBRA Continuation Coverage Rights

MILWAUKEE PUBLIC SCHOOLS PPO/INDEMNITY HEALTH PLAN, EXCLUSIVE PROVIDER ORGANIZATION (EPO) HEALTH PLAN, HIGH DEDUCTIBLE HEALTH PLAN (HDHP), SELF-INSURED INDEMNITY (PPO) DENTAL PLAN, AND THE DELTA DENTAL EPO DENTAL PLAN

Introduction

You are receiving this notice because you are eligible for coverage under the Milwaukee Public Schools PPO/Indemnity Health Plan, Exclusive Provider Organization (EPO) Health Plan, High Deductible Health Plan (HDHP), Self-Insured Indemnity (PPO) Dental Plan and/or the Delta Dental EPO Dental Plan (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. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace.

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.

The Plan Administrator is Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 West Vliet Street, Milwaukee, Wisconsin 53208, Telephone: 414-475-8441, Fax: 414-475-8562. COBRA continuation coverage for the Plan is administered by the Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 West Vliet Street, Room 124, Milwaukee, Wisconsin 53208, telephone 414-475-8441.

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

- 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 MPS, 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 with respect to the bankruptcy. 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 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 West Vliet Street, Milwaukee, Wisconsin 53208, Telephone (414)475-8441, Fax (414)475-8562.

How is COBRA 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 continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Milwaukee Public Schools, Department of Benefits, Pension & Compensation must be notified within 60 days of the later of:(1) the SSA's determination or (2) when your COBRA coverage began (including any period of self-pay coverage deemed to be an election to exercise COBRA coverage), and in every case before the end of the first 18 months of continuation coverage. Notice can include official documentation from the SSA or a copy of the disability award, and notice can be provided by a Qualified Beneficiary or legal representative. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify Milwaukee Public Schools, Department of Benefits, Pension & Compensation, of that fact within 30 days of SSA's determination. Failure to notify MPS within this 30-day time period will result in cancellation of your coverage retroactive to the determination date you were deemed no longer disabled.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the

Plan had the first qualifying event had not occurred. 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. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

If you elect to exercise any rights to self-pay your coverage at the active employee rate while on an approved leave of absence (other than leave under state or federal Family and Medical Leave Acts), any such period of self-paid coverage will be deemed to be an election of COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage.

In considering whether to elect continuation coverage, 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 in your election notice. 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 COBRA 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 (or, in the case of an extension of continuation coverage due to a disability, 150 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. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 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 in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Milwaukee Public Schools, Department of Benefits, Pension & Compensation, Room 124, 5225 West Vliet Street, Milwaukee, Wisconsin, 53208, Telephone 414-475-8441, Fax 414-475-8562, to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments shall be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the last day of the previous month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, 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.

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 after the first day of the coverage period 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 coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Milwaukee Public Schools, Department of Benefits, Pension & Compensation, Room 124, 5225 West Vliet Street, Milwaukee, Wisconsin, 53208.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to: Milwaukee Public Schools, Department of Benefits, Pension & Compensation, Room 124, 5225 West Vliet Street, Milwaukee, Wisconsin 53208, Telephone 414-475-8441, Fax 414-475-8562.

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 or call their toll-free number at 1-866-444-3272. For information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your rights and your family's rights, you should keep the Plan Administrator informed of any changes in your address and 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:

Milwaukee Public Schools
Department of Benefits, Pension & Compensation
5225 West Vliet Street, Room 124
Milwaukee, WI 53208
Telephone: (414)475-8441, Fax (414)475-8562

GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses.

HIPAA Exemption Notices 2020

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Milwaukee Public Schools ("MPS") has elected to exempt the MPS PPO Health Plan, the MPS EPO Health Plan, the MPS High Deductible Health Plan and the MPS Wellness Program from requirements 1, 2, 3 and 4 below:

1. Standards relating to benefits for mothers and newborns.

Group health plans offering health coverage for hospital stays in connection with the birth of a child generally may not restrict benefits for the stay to less than 48 hours for a vaginal delivery and 96 hours for a cesarean section.

2. Parity in the application of certain limits to mental health benefits.

Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

3. Required coverage for reconstructive surgery following mastectomies.

Group health plans that provide medical and surgical benefits for a mastectomy must provide certain benefits in connection with breast reconstruction as well as certain other related benefits.

4. Coverage of dependent students on medically necessary leave of absence.

Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who take a medically necessary leave of absence from a postsecondary education institution.

The exemption from these Federal requirements will be in effect for the plan year beginning January 1, 2020 and ending December 31, 2020. The election may be renewed for subsequent plan years.

NOTE: The MPS PPO Health Plan, MPS EPO Health Plan, the MPS High Deductible Health Plan and MPS Wellness Program, in accordance with Board Administrative Policies, currently provide benefits that are similar to HIPAA requirements 1, 2, 3 and 4 above.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption to this requirement. The certificate provides evidence that you were covered under these health plans, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate preexisting condition exclusion if you join another employer's health plan or if you wish to purchase an individual health insurance policy.

Any questions concerning this notice may be directed to:
Milwaukee Public Schools
Department of Benefits, Pension & Compensation
5225 West Vliet Street, Room 124
Milwaukee, WI 53208
Phone: 414-475-8217; FAX: 414-475-8562

This notice is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) *November 2019*

Mandatory Social Security Number Reporting Requirement

A Federal law has been passed (Section 111 of Public Law 111-173) that requires you to provide your and your covered dependent's Social Security Numbers ("SSN") to your group health plan.

As a covered participant of a group health plan, your SSN will likely be requested in order to meet the requirements of P.L. 110-173 if this information is not already on file with your group health plan.

Your SSN will be reported to Medicare so that a determination can be made of which plan is to pay primary when dual coverage exists with Medicare.

If you do not provide your and your dependent's SSN, your Employer may face a substantial penalty for non-compliance.

If you have any questions about this reporting requirement, please contact the Office of Human Resources, Department of Benefits, Pension & Compensation at 414-475-8217.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Milwaukee Public Schools health plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice in Open Enrollment to request enrollment. For more information contact the Office of Human Resources, Department of Benefits, Pension & Compensation at 414-475-8217.

Notice of Creditable Coverage

Important Notice From Milwaukee Public Schools
PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Milwaukee Public Schools has determined that the prescription drug coverage offered by OptumRx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Your (and/or your covered dependents) MPS health insurance coverage is on average as good as standard Medicare coverage and you (and/or your covered dependents) are not required to enroll in a Medicare prescription drug plan now to avoid paying a penalty (higher premium) for later enrollment. Remember that the premium for the Medicare plan is your responsibility to pay. The options for you and your eligible, covered dependents are as follows:

a. You can maintain your MPS health insurance coverage and NOT enroll/pay for a Medicare prescription drug plan. If you do this, you will not have to pay the premium for a Medicare prescription drug plan and your prescription drug coverage will be provided by your MPS health insurance plan.
b. You can maintain your MPS health insurance coverage and enroll/pay for a Medicare prescription drug plan. You will

still be eligible to receive MPS health insurance plan benefits which cover other health insurance expenses in addition to prescription drug coverage. However, you have to pay the Medicare prescription drug plan premium.

c. You can cancel your MPS health insurance coverage and enroll/pay for a Medicare prescription drug plan. However, your MPS health insurance plan covers other health insurance expenses in addition to prescription drug coverage and you CANNOT get your MPS coverage back. It is important that you consider this in any decision that you make to cancel your MPS coverage and purchase a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current MPS health coverage, be aware that you and your dependents will not be able to get this coverage back.

Please keep in mind that if you drop your MPS health plan and choose the Medicare prescription plan or any other Medigap plan, you and/or your covered dependents may not have the same access and level of benefits as MPS provides for prescription drugs, hospital, and other medical services. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area before deciding to drop your MPS health plan.

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

You should also know that if you drop or lose your current coverage with Milwaukee Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact OptumRx at 1-877-440-5982. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MPS changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/03/2019
Name of Entity/Sender: MILWAUKEE PUBLIC SCHOOLS
Contact—Position/Office: Department of Benefits, Pension & Compensation
Address: P.O. Box 2181, Milwaukee, WI 53201-2181
Phone Number: (414)475-8441

Notice of Opportunity to Enroll in Connection With Extension of Dependent Coverage to Age 26

For health plans beginning on or after September 23, 2010, young adults are allowed to stay on their parent's employer's health plan until they turn 26 years old. Before the health care law, insurance companies could remove enrolled children usually at age 19, sometimes older for full-time students. Now, most health plans that cover children must make coverage available to children up to age 26. By allowing children to stay on a parent's plan, the law makes it easier and more affordable for young adults to get health insurance coverage.

Your children can join or remain on your plan even if they are:

- Married
- Not living with you
- Attending school
- Not financially dependent on you
- Eligible to enroll in their employer's plan

Notice of Privacy Practices

THE PRIVACY OF YOUR MEDICAL AND DENTAL INFORMATION IS IMPORTANT TO US

This notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information.

We are required by applicable Federal and State laws to maintain the privacy of your protected health information. Protected health information is defined as individually identifiable health information that is transmitted in electronic media or maintained in any medium described in the definition of electronic media in the Privacy Rules issued by the U.S. Department of Health and Human Services at 45 C.F.R. § 162.103 or transmitted or maintained in any other form or medium. The term "health information" in this notice includes any personal information that is created or received by a health or dental care provider or health or dental plan that relates to your physical, dental, or mental health condition, the provision of health or dental care to you, or the payment for such health or dental care. It does not include individually identifiable health information contained in education records covered by the Family Educational Rights and Privacy Act, records described in 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by the Milwaukee Board of School Directors.

We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect July 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

OUR USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose medical information about you as follows:

- **Treatment:** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **Payment:** We may use and disclose your health information to obtain payment of premiums, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have or to assist with payment of claims from doctors, hospitals and other providers for services delivered to you that are covered by your health or dental plan, to determine your eligibility for benefits, to assist with coordination of benefits, to obtain premiums, to disclose whether or not an individual is participating in the group health or dental plan and the like. For example, we may tell a doctor whether you are eligible of coverage and what percentage of the bill may be covered.
- **Health Care Operations:** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use and disclose your health information to rate our risk and determine our premiums for your health or dental plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to manage our business, and the like.

We may use and disclose medical information about you as follows:

- **You and Your Authorization:** We must disclose your health information to you, as described below in Your Rights section of this notice. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your health information for any reason except those described in this notice. The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes if recorded by us; (ii) uses and disclosures of health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of health information; and (iv) other uses and disclosures not described in this Notice.
- **Your Family and Friends:** We may disclose to a family member, a friend, or other persons you indicate are involved in your care or payment for your care, your health information that is directly relevant to their involvement. We may use or disclose your name, location, and general condition or death to notify or help with notification of a family member, your personal representative, or other persons involved in your care about your situation. If you are present, we will give you the opportunity to object before we disclose your health information to these persons. If you are incapacitated or in an emergency, we may disclose your health information to these persons if we determine that the disclosure is in your best interest.
- **Underwriting:** We may receive your health information for premium rating or other activities relating to the creation, renewal or replacement of a contract of health or dental insurance or health or dental benefits. We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.
- **Disaster Relief:** We may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.
- **Death, Organ Donation:** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **Public Health and Safety:** We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your health information to a government agency authorized to oversee the health care system or government programs or its contractors and to public health authorities for public health purposes. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes.
- **Plan Sponsor:** We may disclose your protected health information to the Milwaukee Board of School Directors as plan sponsor to carry out plan administration functions that it performs upon certification by the plan sponsor that it has adopted provision to appropriately protect health information. We may disclose summary information about the members of the PPO Health Plan, Exclusive Provider Organization (EPO) Health Plan, HDHP and Self-Insured Indemnity (PPO) Dental Plan for the plan sponsor to use to obtain premium and cost information, or to decide whether to seek modifications of the PPO Health Plan, EPO Health Plan, HDHP, and Self Insured Indemnity (PPO) Dental Plan. We may also disclose eligibility, enrollment and disenrollment information to the Plan sponsor.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law. For example, we must disclose your health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings:** We may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.
- **Law Enforcement:** Under circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your health information to law enforcement officials. We may disclose limited health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security:** We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

- **Access:** You have the right to review or obtain copies of your health information in our possession, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.25 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.
- **Disclosure Accounting:** You have the right to receive an accounting of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information, (i) made prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- **Restriction Requests:** You have the right to ask to restrict our uses and disclosures of your health information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or others who are involved in your health care or payment for your health care. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We are also required to agree to a request to restrict disclosure of your health information to a health plan if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the health information pertains solely to a health care item or service for which you or a person other than the health plan on your behalf, had paid in full. Any request to restrict must be made in writing and should identify (i) the information to be restricted; (ii) the type of restriction being requested (for example, the use or disclosure, or both), and (iii) to whom the limits should apply.
- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your health information by alternative means or to an alternative location. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Electronic Notice:** If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.
- **Notification of Breach:** We are required to notify you of any breach of your unsecured protected health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information as listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFORMATION:
Milwaukee Public Schools
Department of Benefits, Pension & Compensation
5225 West Vliet Street, Room 124
Milwaukee, WI 53208
Phone: 414-475-8217; FAX: 414-475-8562

Patient Protection Disclosure

You do not need prior authorization from Milwaukee Public Schools health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact our third party administrator, UnitedHealthcare at 1-877-440-5982.

Plan Status: Non-Grandfathered Plan

Your MPS plan is classified as Non-Grandfathered.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, Wisconsin may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Wisconsin, you can contact the Wisconsin Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you have questions about enrolling in your employer plan, you can contact the Department of Labor at **www.askebsa.dol.gov** or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U. S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U. S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, or 60 days after the birth, adoption or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact the Office of Human Resources, Department of Benefits, Pension & Compensation at 414-475-8217.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What Is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Department of Benefits, Pension & Compensation at 414-475-8217. For more information regarding the Marketplace please call 1-800-318-2596.

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

_____

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

PART B: Information About Health Coverage Offered by Your Employer

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

<table>
<tr><td colspan="2">3. Employer name
Milwaukee Board of School Directors</td><td colspan="2">4. Employer Identification Number EIN
39-6003457</td></tr>
<tr><td colspan="2">5. Employer address
5225 West Vliet Street</td><td colspan="2">6. Employer phone number
414-475-8217</td></tr>
<tr><td>7. City
Milwaukee</td><td>8. State
WI</td><td colspan="2">9. Zip Code
53208</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
MPS Department of Benefits, Pension & Compensation</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td colspan="2">12. Email address
MPSEmployeeBenefits@milwaukee.k12.wi.us</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - □ All employees.
  - ☑ Some employees. Eligible employees are: Employees regularly scheduled to work in benefit eligible positions of 30 hours or more per week.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: The following individuals who meet specific eligibility requirements include spouse, dependent child, grandchild, legal ward. For more information, active employees may go to the MPS website under mConnect and retirees may go to the MPS Website, **http://mps.milwaukee.k12.wi.us** , click Employment > Retirement & Pensions, Retirement Health Benefits.

□ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

Summary of Benefits and Coverage

In accordance with the requirements of the Affordable Care Act ("ACA" also known as the health care reform law), a Summary of Benefits and Coverage ("SBC") is now available on mConnect and on the MPS Website, **http://mps.milwaukee.k12.wi.us** , click Employment > Retirement & Pension > Retirement Health Benefits.

Question: What is a Summary of Benefits and Coverage (SBC)?

Answer: It is an eight-page document that is mandated by the government that presents key, standardized information about your current health plan coverage. The government's intent is to provide a concise document explaining, in plain language, simple and consistent information about health plan benefits and coverage. It summarizes the key features of the health plan, such as the covered benefits, cost-sharing provisions, coverage limitations and provides two coverage examples. The content and formatting requirements are strict and used industry-wide throughout the United States to allow easy comparison of coverage options between plans and carriers.

Question: What is the Glossary referred to in the SBC?

Answer: It is a glossary compiled by the government of commonly used definitions of health coverage and medical terminology, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions for a particular health plan. Some of the terms also might not have exactly the same meaning when used in a policy or a plan, and in any such case, the policy or plan governs. The Glossary is mandated to be provided in connection with the SBC and cannot be modified.

Question: How can I access the SBC and the Glossary on the MPS website?

Answer: You do not need a password to access the website to obtain the SBC that pertains to the MPS health plan you are enrolled in. Active employees may go to mConnect and retirees may go to the MPS Website, **http://mps.milwaukee.k12.wi.us**, click Employment > Retirement & Pensions > Retirement Health Benefits. If you want more detailed information about your benefits, please contact UnitedHealthcare at 1-877-440-5982 for medical and pharmacy benefits. We thank you for your continued cooperation.

Women's Health & Cancer Rights Acts of 1998

On October 21, 1998, Congress passed a law entitled the "Women's Health & Cancer Rights Act of 1998." The Act requires that all health plans offering mastectomy coverage shall also provide benefits for the following services:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

Prostheses and physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

Your MPS Health Plan provides breast reconstruction benefits and will continue to provide covered benefits and services that are consistent with this law. These benefits are provided in a manner which is determined in consultation with your doctor. Coverage for these services is subject to all of the same limitations, exclusions and cost-sharing provisions that apply generally (including annual deductibles and coinsurance provisions) to all other services provided under your policy. Written notice of the availability of such coverage shall be delivered to participants upon enrollment and annually thereafter.

ADDITIONAL NOTICES

Employer-Provided Health Insurance Offer and Coverage (1095-C) for Active Employees, Applicable COBRA Participants and Non-Medicare Retirees*

In accordance with the requirements of the Affordable Care Act ("ACA") also known as the health care reform law, all employees (applicable COBRA or non-Medicare retirees as well) who were full-time or were covered under an MPS non-Medicare plan for one or more months of the 2019 calendar year will receive a form 1095-C. This form is used to report your offer of health coverage and enrollment in health coverage from Milwaukee Public Schools and will also be filed and furnished to the IRS. If applicable, you can expect to receive this 1095-C by January 31, 2020, and will report to you (the employee, applicable COBRA participant, or non-Medicare retiree) and your covered dependents, if applicable, that you were offered minimum essential coverage under a MPS plan. When filing your tax return, you will use this form to report your insurance coverage during the year to comply with the Affordable Care Act.

☐ VOID ☐ CORRECTED OMB No. 1545-2251 **2017** Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

Part I APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

Milwaukee Public Schools
5225 W Vliet St
Room 124
Milwaukee WI 53208-
414/475-8217

▶ Do not attach to your tax return. Keep for your records. Go to *www.irs.gov/Form1095C* for instructions and the latest information.

EMPLOYEE'S name, address, ZIP/postal code & country

John Doe
1234 Main Street
Milwaukee, WI 53208

INFORMATION ONLY

APPLICABLE LARGE EMPLOYER'S identification number (EIN)	EMPLOYEE'S social security number (SSN)
39-6003457	XXX-XX-1234

Part II Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.):	14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months		$	
Jan	1A	$	2C
Feb	1A	$	2C
Mar	1A	$	2C
Apr	1A	$	2C
May	1A	$	2C
June	1A	$	2C
July	1A	$	2C
Aug	1A	$	2C
Sept	1A	$	2C
Oct	1A	$	2C
Nov	1A	$	2C
Dec	1A	$	2C

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Department of the Treasury -- IRS

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 mos.	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	John Doe	XXX-XX-1234			X	X	X	X	X	X	X	X	X	X	X	X
18	Jane Doe	XXX-XX-5678			X	X	X	X	X	X	X	X	X	X	X	X
19	Jim Doe	XXX-XX-9123			X	X	X	X	X	X	X	X	X	X	X	X
20																

*Information current as of the date of publication. For informational purpose only – MPS cannot provide tax advice.

Appeal Procedure for Health Plans (PPO, EPO, HDHP)

Claims Denials and Appeal

In general, if a claim for benefits is denied in part or in whole, you may call UnitedHealthcare (UHC) at the number on your ID card (1-877-440-5982) before requesting a formal appeal. If UHC cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for benefits or for a post-service claim, you or your authorized representative must submit your appeal in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request

You may draft your written communication including the information listed above or you may use a Member Service Request Form located on the UHC member website. Log-in under your user name and password, click on the Claims & Accounts tab; at the bottom of the page under forms click on Medical Appeals and Grievances and then click on the applicable (in most cases Wisconsin) Member Services Request Form. You or your authorized representative may send this written request for an appeal to: UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

You do not need to submit urgent care appeals in writing. For Urgent Care requests for benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card (1-877-440-5982) to request an appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your health plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Milwaukee Public Schools. Instructions are included with the first level appeal determination letter from UnitedHealthcare. For a second level appeal, please include your written appeal request, a copy of the first appeal denial determination letter from UnitedHealthcare, and any additional documentation that supports your second level appeal request. Second level appeals can be sent to:

Milwaukee Public Schools
Department of Benefits, Pension & Compensation
5225 West Vliet Street, Room 124
Milwaukee, WI 53208

Voluntary External Review

If after exhausting the two levels of appeal you are not satisfied with the final determination, you may choose to participate in the voluntary external review program. Any request for external review must be filed within 125 days after you receive UnitedHealthcare's final decision on an internal claims appeal.

You can submit a request for external review by contacting UnitedHealthcare at: UnitedHealthcare-Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432
Phone: 1-877-440-5982

Dependent Status Change Required Notices

IMPORTANT NOTICE FOR PLAN PARTICIPANTS

You are required to notify MPS Department of Benefits, Pension & Compensation of the following insurance information and events as they occur throughout the year to remove ineligible dependents from your plans. Notification is required within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage).

If you divorce:

- Your ex-spouse and your step-child(ren) from that marriage are no longer eligible to be covered as dependents under MPS health and dental plans
- **You must remove ineligible dependents** from your MPS health and dental plan by contacting MPS and completing an MPS Benefits Termination Form
- If your ineligible dependents are kept on MPS health/dental plans, you can face penalties up to and including discipline, termination of employment and repayment to MPS for claims/premiums paid for ineligible dependents
- Failure to notify MPS within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) may also result in the loss of rights to self-pay for COBRA continuation coverage

If your spouse or other covered dependent dies:

- **You must notify MPS in writing** so we can remove them from your MPS health or dental plan
- Upon receipt of your notification, we will send you an MPS Benefits Termination Form that you must complete. We accept your signed & completed form as your notice; we do not require a death certificate

If you are enrolled/changed/cancelled other medical or prescription coverage:

- **You must notify UnitedHealthcare** by calling 1-877-440-5982 as soon as possible when the change occurs
- You can avoid service problems since MPS benefit plans coordinates your benefits with other plans

If you are under Age 65 & Medicare eligible due to a disability:

- **You must inform MPS in writing** and send a copy of your Medicare Card

If you are eligible for Medicare and did not enroll:

- **You must enroll in Medicare Part B** if you are retired, or are the spouse of a retiree, and eligible, regardless of whether or not you are enrolled in Social Security

REMEMBER…….
It is <u>your</u> responsibility to notify MPS within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) to remove ineligible dependents from your MPS health and dental plans.

If you have any questions, please contact: Milwaukee Public Schools
Department of Benefits, Pension & Compensation, Room 124
P.O. Box 2181
Milwaukee, Wisconsin 53201-2181
Telephone: 414-475-8217 Fax: 414-475-8562

NOTICE: MPS reserves its rights to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. It is <u>your</u> responsibility to notify MPS Department of Benefits, Pension & Compensation within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) to remove your ineligible dependent(s) from your MPS health and/or dental plan.

Notice of Establishment of the Milwaukee Board of School Directors Post-Employment Benefits Trust

On May 27, 2010 the Milwaukee Board of School Directors authorized the establishment of the Milwaukee Board of School Directors Post-Employment Benefits Trust under Internal Revenue Code Section 115 for the purpose of funding costs associated with post-employment benefits other than pension; e.g., health and life insurance. Employees can view the Trust Agreement by making a written request to Milwaukee Public Schools, Department of Benefits, Pension & Compensation.

Subrogation and Reimbursement Notice for MPS EPO/PPO/HDHP Plans

How your benefits are impacted if you suffer a sickness or injury caused by a third party?
The Plan has a right to subrogation and reimbursement.

Right of Recovery
The Plan has the right to recover benefits it has paid on you or your dependent's behalf that were made in error; or due to a mistake in fact; or advanced during the time period of meeting the calendar year deductible; or advanced during the time period of meeting the Out-Of-Pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.
If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will require that the overpayment be returned when requested, or reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of the deductible and/or meeting the Out-Of-Pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan; and conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation
The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident. The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement
The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Third Parties
The following persons and entities are considered third parties: a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages; any insurer or other indemnifier of any person or entity who caused the sickness, injury or damages; Milwaukee Public Schools in workers' compensation cases; or any person or entity who is or may be obligated to provide you with benefits or payments under underinsured or uninsured motorist insurance; medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise); workers' compensation coverage; or any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions
As a covered person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party;

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right;
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

Benefits paid by the Plan may also be considered to be benefits advanced. You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- complying with the terms of this section;
- providing any relevant information requested;
- signing and/or delivering documents at its request;
- notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
- responding to requests for information about any accident or injuries;
- appearing at medical examinations and legal proceedings, such as depositions or hearings; and
- obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval. Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a sickness or injury caused by a third party.

The Plan's rights will not be reduced due to your own negligence.

The Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.

The provisions of this section apply to the parents, guardian or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate and your heirs.

Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

If a third party causes you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a covered person.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

IMPORTANT NOTICE/DISCLAIMER

This summary provides highlights of the Milwaukee Public Schools (MPS) health and dental benefits offered to benefit-eligible employees of MPS. This publication describes these benefits in general terms only as of the publication date indicated and is not intended to be a complete description of coverage. All benefit and eligibility provisions described herein are subject to, and subordinate to, the terms and provisions of the master plan document or contract for each plan, Board policies and procedures, and State and Federal law, and are not intended to, and shall not be construed to, create any rights that in any manner exceed or modify the terms and conditions of the benefit plans as set forth in or mandated by these other sources. MPS reserves the right to modify, amend, repeal or terminate any provision or plan summarized herein, and any Board policy or procedure, consistent with State or Federal law, at any time with or without notice. This summary and any of the sources referenced herein are not intended and should not be construed to be a contract of employment, express or implied.

Non-Discrimination Notices

Nondiscrimination Notice

It is the policy of the Milwaukee Public Schools, as required by section 118.13, Wisconsin Statutes, that no person will be denied admission to any public school or be denied the benefits of, or be discriminated against in any curricular, extracurricular, pupil services, recreational or other program or activity because of the person's sex, race, color, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability.

This policy also prohibits discrimination under related federal statutes, including Title VI of the Civil Rights Act of 1964 (race, color, and national origin), Title IX of the Education Amendments of 1972 (sex), and Section 504 of the Rehabilitation Act of 1973 (disability), and the Americans with Disabilities Act of 1990 (disability).

The following individuals have been designated to handle inquiries regarding student non-discrimination policies:
For section 118.13, Wisconsin Statutes, federal Title IX: Matthew Boswell, Director, Department of Student Services, Room 133, Milwaukee Public Schools, 5225 W. Vliet St., P.O. Box 2181, Milwaukee, Wisconsin, 53201-2181 (414) 475-8027.

For Section 504 of the Rehabilitation Act of 1973 (Section 504), federal Title II: Travis Pinter, 504/ADA Coordinator for Students, MPS Department of Specialized Services, 6620 W. Capitol Drive. (414) 438-3677.

Employment Nondiscrimination

Milwaukee Public Schools is committed to equal employment opportunity and non-discrimination as required by the law for all individuals in the MPS workplace regardless of race, color, ancestry, religion, gender, sex, national origin, disability, age, creed, sexual orientation, marital status, veteran status, or any other legally protected characteristic or legally protected activity (e.g., participation in the complaint process). MPS will not tolerate adverse treatment based on a legally protected characteristic or legally protected activity involving equal employment opportunity.

Therese Freiberg (414) 773-9927; freibetm@milwaukee.k12.wi.us Interim Manager, Employee Rights Administrative Department (ERAD), has been designated to respond to requests for disability-related job accommodations. Therese Freiberg and the EEO Compliance Administrator in ERAD, (414) 773-9876; has been designated to respond to internal complaints regarding employment discrimination. ERAD can be contacted in the Office of Human Resources at Milwaukee Public Schools, 5225 W. Vliet Street, Room 128, P.O. Box 2181, Milwaukee, WI 53201-2181.

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Language Assistance Services: UnitedHealthcare EPO, PPO, and HDHP member toll-free #: 1-877-440-5982

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: ប៉ើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

IMPORTANT CONTACTS

Vendor	Phone Number	Customer Service Hours	Website
Delta Dental	1-800-236-3712 IVR (Interactive Voice Response) & Voicemail	7:30 a.m. - 5 p.m. Monday-Friday 24 hours, 7 days a week	www.deltadentalwi.com
National Vision Administrators (NVA)	1-800-672-7723	24 hours a day, 7 days a week	www.e-nva.com
Optum Bank (HSA)	1-844-326-7967	24 hours a day, 7 days a week	https://www.optumbank.com/
UnitedHealthcare (EPO, PPO, and HDHP) and OptumRx	1-877-440-5982	7 a.m. – 8 p.m. Monday-Friday	www.myuhc.com For EPO: Under links and tools click on Find Physician, Laboratory or Facility; choose "Medical Directory," then choose "All UnitedHealthcare Plans," then choose "Choice." www.myuhc.com for PPO and HDHP: Under links and tools click on Find Physician, Laboratory or Facility; choose "Medical Directory," then choose "All UnitedHealthcare Plans," then choose "Choice Plus."
UnitedHealthcare Advocate4Me	1-877-440-5982	7 a.m. – 8 p.m. Monday-Friday	www.myuhc.com
UHC's Employee Nurse Line	1-855-262-3438	24 hours, 7 days a week	

APPENDIX A: HEALTH PLAN DESIGN

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
ANNUAL PLAN DEDUCTIBLE	Individual: $750 Family: $2,250 (3 individuals)	Individual: $1,500 Family: $4,500 (3 individuals)	Individual: $350 Family: $1,050 (3 individuals)	Individual: $1,600 Family: $3,200	Individual: $3,200 Family: $6,400
COINSURANCE	Plan Pays 80%	Plan Pays 50%	Plan Pays 80%	Plan Pays 80%	Plan Pays 50%
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM	Includes deductible, coinsurance, medical co-pays; Excludes prescription co-pays. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance, medical co-pays; Excludes prescription co-pays. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance, medical co-pays; Excludes prescription co-pays. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance and covered prescription cost share. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance and covered prescription cost share. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM	Single: $3,250 Family: $9,750	Single: $4,500 Family: $13,500	Single: $1,350 Family: $4,050	Single: $3,200 Family: $6,400	Single: $6,400 Family: $12,800
PHARMACY COVERAGE	(Prescription drug coverage provided by OptumRx Participating Pharmacies)				
PHARMACY OUT-OF-POCKET MAXIMUM	Individual: $4,100 Family: $4,950	N/A	Individual: $6,000 Family: $10,650	Included in Medical Out-Of-Pocket Maximum	N/A
RETAIL PHARMACY	Tier 1: Generic $8 co-pay Tier 2: Preferred Brand-name 10% with a $25 Minimum co-pay Tier 3: Non-preferred Brand-name 20% with a $50 Minimum co-pay Multi-Source Brand: Member-Pay-Difference*	None	Tier 1: Generic $8 co-pay Tier 2: Preferred Brand-name 10% with a $25 Minimum co-pay Tier 3: Non-preferred Brand-name 20% with a $50 Minimum co-pay Multi-Source Brand: Member-Pay-Difference*	80% after Deductible	None

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
RETAIL PREVENTIVE PHARMACY **(Applies to HDHP– Refer to preventive drug list available on mConnect/MPS website)**	Same as Retail Pharmacy	None	Same as Retail Pharmacy	Tier 1: Generic $8 co-pay Tier 2: Preferred Brand-name 10% with a $25 Minimum co-pay Tier 3: Non-preferred Brand-name 20% with a $50 Minimum co-pay Multi-Source Brand: Member-Pay-Difference*	None
MAIL ORDER PHARMACY	Tier 1: Generic $16 co-pay Tier 2: Preferred Brand-name $50 co-pay Tier 3: Non-preferred Brand-name $100 co-pay Multi-Source Brand: Member-Pay-Difference*	None	Tier 1: Generic $16 co-pay Tier 2: Preferred Brand-name $50 co-pay Tier 3: Non-preferred Brand-name $100 co-pay Multi-Source Brand: Member-Pay-Difference*	80% after deductible (pricing discounts at mail order)	None
MAIL ORDER PREVENTIVE PHARMACY	Same as Mail Order Pharmacy	None	Same as Mail Order Pharmacy	Tier 1: Generic $16 co-pay Tier 2: Preferred Brand-name $50 co-pay Tier 3: Non-preferred Brand-name $100 co-pay Multi-Source Brand: Member-Pay-Difference*	None

***Member-Pay-the-Difference: Member pays the $8 Retail Generic ($16 Mail Order Generic) co-pay plus the gross cost difference between the Brand and equivalent Generic. This additional cost is excluded from the OOP limit.**

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
AMBULANCE	80% after deductible	80% after deductible**	80% after deductible	80% after deductible	80% after deductible**
HOSPITAL SERVICES Inpatient Outpatient (includes outpatient therapeutic treatments) Surgery Physician In-Hospital Services	80% after deductible	50% after deductible**	80% after deductible	80% after deductible	50% after deductible**
PHYSICIAN SERVICES Office Visits – Primary Care Physician (Non-Surgical)	100% after $20 co-pay per visit	50% after deductible	100% after $20 co-pay per visit.	80% after deductible	50% after deductible**
ROUTINE PHYSICALS	100% after $20 co-pay per visit SEE PREVENTIVE CARE	50% after deductible	100% after $20 co-pay per visit. SEE PREVENTIVE CARE	100% For Preventive Care; 80% after deductible if not covered under Preventive	50% after deductible
IMMUNIZATIONS	100% after $20 co-pay; $35 co-pay if Specialist SEE PREVENTIVE CARE	50% after deductible	100% after $20 co-pay; $35 co-pay if Specialist SEE PREVENTIVE CARE	100% for Preventive Care	50% after deductible
PREVENTIVE CARE	100% of eligible expenses	50% after deductible	100% of eligible expenses	100% of eligible expenses	50% after deductible

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
SPECIALISTS (Office Visits) Other Physician Services	$35 co-pay per office visit.	50% after deductible	$35 co-pay per office visit.	80% after deductible	50% after deductible**
CONTRACEPTIVES	100% no deductible as specified under Health Care reform.	50% after deductible	100% no deductible as specified under Health Care Reform.	100% no deductible as specified under Health Care Reform	50% after deductible
DENTAL SERVICES Oral Surgery Accident Only	80% after deductible-specific list of oral procedures covered. Dental implants excluded. 80% after deductible and within 72 hrs of accident	50% after deductible-specific list of oral procedures covered.** Dental implants excluded. 80% after deductible and within 72 hrs of accident	80% after deductible-oral surgery limited to surgical removal of impacted wisdom teeth <u>only</u>. Dental implants excluded. 80% after deductible and within 72 hrs of accident	80% after deductible Oral surgery limited to surgical removal of impacted wisdom teeth <u>only</u>. Dental implants excluded.	50% after deductible** Oral surgery limited to surgical removal of impacted wisdom teeth <u>only</u>. Dental implants excluded.
DURABLE MEDICAL EQUIPMENT (Including cochlear implants)	80% after deductible	50% after deductible**	80% after deductible; single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.	80% after deductible; Single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.	50% after deductible** Single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.
EMERGENCY HEALTH SERVICES Non-Emergency use of Emergency Health Services	100% after $150 co-payment per visit 50% after deductible	100% after $150 co-payment per visit** 50% after deductible	100% after $125 co-payment per visit 50% after deductible	80% after deductible Not covered	80% after deductible** Not covered
HEARING AIDS For dependent children under 18 years of age. Limit of one hearing aid per ear every three years.	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
HOME HEALTH CARE	80% after deductible Up to 120 visits per calendar year, combined in and out-of-network.	50% after deductible** Up to 120 visits per calendar year, combined in and out-of-network.	80% after deductible, up to maximum of 60 visits when approved in advance by UHC Care Coordination.	80% after deductible, up to maximum of 60 visits when approved in advance by UHC Care Coordination.	50% after deductible** Up to maximum of 60 visits when approved in advance by UHC Care Coordination.
HOSPICE CARE	80% after deductible Lifetime maximum up to 45 days for inpatient care, combined & out-of-network	50% after deductible** Lifetime maximum up to 45 days for inpatient care, combined & out-of-network	80% after deductible Lifetime maximum up to 360 days.	80% after deductible	50% after deductible**
INFERTILITY SERVICES (including artificial insemination, assisted reproductive technologies, and in vitro fertilization)	$35 co-payment per office visit, 80% after deductible Lifetime maximum of $30,000; combined in and out-of-network	50% after deductible** Lifetime maximum of $30,000; combined in and out-of-network	$35 co-pay per office visit. 80% after deductible Lifetime maximum of $2,000	Exclusion: Health services and associated expenses for infertility treatments including assisted reproductive technology regardless of reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.	Exclusion: Health services and associated expenses for infertility treatments including assisted reproductive technology regardless of reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
LAB, X-RAY, DIAGNOSTICS and THERAPEUTIC TREATMENTS - OUTPATIENT (including allergy testing, chemotherapy, MRI, CT, etc.) For preventive lab/x-ray procedures, refer to Preventive Care services category.	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible**

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
MENTAL HEALTH SERVICES Inpatient Outpatient (Includes transitional treatment)	80% after deductible 100% after $20 co-payment per visit	50% after deductible** 50% after deductible**	80% after deductible 100% after $20 co-payment Prior authorization through UHC Designee is required	80% after deductible 80% after deductible	50% after deductible** 50% after deductible**
OBESITY/WEIGHT LOSS (when medically necessary & must meet certain criteria)	$35 co-pay per office visit	50% after deductible**	Not covered	Not covered	Not covered
PREGNANCY-MATERNITY SERVICES (including voluntary sterilization and voluntary abortion)	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category. For services provided in the physician's office, a co-payment will only apply to the initial visit.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category. For services provided in the physician's office, a co-payment will only apply to the initial office visit.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.
PRIVATE DUTY NURSING (outpatient only) Limit of 70 visits per year, combined in and out-of-network.	80% after deductible	50% after deductible**	N/A	N/A	N/A
PROSTHETIC/ORTHOTIC DEVICES	80% after deductible please call UHC for restrictions on foot orthotics.	50% after deductible** Please call UHC for restrictions on foot orthotics.	80% after deductible; single device every three years as specified and approved through UHC Care Coordinator. Orthotics not covered.	80% after deductible Orthotics not covered.	50% after deductible** Orthotics not covered

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
REHABILITATION SERVICES-OUTPATIENT THERAPY (INCLUDING PT, OT, SPEECH, ETC.) and MANIPULATIVE TREATMENT All care coordinated by Optum of UHC.	100% after $20 co-payment per visit	50% after deductible**	100% after $20 co-pay; limit of 20 visits of each: PT, OT, speech, pulmonary, and cognitive rehab, and 36 visits of cardiac rehabilitation per calendar year.	80% after deductible Limit of 20 visits of each: PT, OT, speech, pulmonary, and cognitive rehab, and 36 visits of cardiac rehabilitation per calendar year.	50% after deductible** Limit of 20 visits of each: PT, OT, speech, pulmonary, and cognitive rehab, and 36 visits of cardiac rehabilitation per calendar year.
SCOPIC PROCEDURES-OUTPATIENT DIAGNOSTIC and THERAPEUTIC For preventive scopic procedures, refer to Preventive Care services category.	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible
SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY	80% after deductible Up to 120 days per calendar year, combined in and out-of-network.	50% after deductible** Up to 120 days per calendar year, combined in and out-of-network.	80% after deductible, maximum of 30 days per inpatient stay for care in conjunction with discharge from hospital and 60 days per calendar year for inpatient rehabilitation facility	80% after deductible Combined limit in and out-of-network of 60 days per year	50% after deductible** Combined limit in and out-of-network of 60 days per year
SUBSTANCE USE DISORDER SERVICES Inpatient Outpatient (Includes transitional treatment)	80% after deductible 100% after $20 co-payment per visit	50% after deductible** 50% after deductible**	80% after deductible 100% after $20 co-payment per visit	80% after deductible 80% after deductible	50% after deductible** 50% after deductible**

BENEFITS / SERVICES *Subject to Medical Necessity*	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
TEMPOROMANDIBULAR JOINT SERVICES DIAGNOSTIC and NON-SURGICAL TREATMENT	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**
TRANSPLANTATION SERVICES	80% after deductible, services must be received at a Designated Facility; in conjunction with National Program for Medical Excellence.	50% after deductible in conjunction with National Program for Medical Excellence.**	80% after deductible Pre-Service Notification Required. Must be received at a designated facility**	80% after deductible Pre-Service Notification Required. Must be received at a designated facility **	Non-network benefits are not available
URGENT CARE/WALK-IN CLINIC	100% after $35 co-payment per visit	50% after deductible	100% after $35 co-pay for designated urgent care centers and doctor offices.	80% after deductible	50% after deductible
VISION EXAMINATION (ROUTINE)	Not Covered	Not Covered	100% after $20 co-payment per visit, limited to 1 exam every 2 years	Not Covered	Not Covered

****Preauthorization is required or benefits will be reduced. If you are admitted to a Hospital as a result of an Emergency, you must notify UHC within 2 business days of the admission. In addition to the above categories, preauthorization by the member is required for out-of-network services for the following: clinical trials, congenital heart disease services, genetic testing-BRCA, neurological disorders/mental health services for autism spectrum disorder, reconstructive procedures and therapeutics. Please contact UnitedHealthcare for specific preauthorization requirements.**

APPENDIX B: DENTAL/VISION

DENTAL PLANS COMPARISON

This comparison is only illustrative. Actual benefits, limitations and exclusions are contained in plan documents.

DENTAL BENEFITS **Does not duplicate medical coverage**	DELTA DENTAL PPO	DELTA DENTAL EPO* **In-Network Providers Only**
ANNUAL MAXIMUM Per Person	$1,500 January 1 – December 31	$3,000 January 1 – December 31
ANNUAL DEDUCTIBLE	$25 (maximum 3 per family)	$25 per person
DIAGNOSTIC Oral exam, x-rays	100% no deductible	100% not applied toward annual maximum, no deductible
PREVENTIVE Cleaning, fluoride	100% no deductible Cleanings twice per calendar year Fluoride up to age 19 Sealants to age 19	100% not applied towards annual maximum, no deductible Cleanings twice per calendar year Fluoride up to age 19 Sealants to age 19
RESTORATIVE Fillings, pre-fab crowns	80%	100%
CROWNS	80%	80%
ENDODONTICS Root Canals	80%	100%
ORAL SURGERY	80%	100%
PERIODONTICS Treatment of Gums	80%	100%
PROSTHODONTICS Bridges, dentures	50%	80%
ORTHODONTICS Complete treatment Eligibility	50% to a lifetime maximum of $1,500 (no deductible) Children to Age 19	50% coverage with a $750 maximum out-of-pocket per person**; thereafter 100% coverage Children to Age 19

* The Delta Dental EPO (previously Care Plus) plan only provides coverage for services from a Delta Dental PPO provider. This coverage includes all Dental Associates facilities and more. To find an in-network dentist go to: www.deltadentalwi.com, select "Find A Dental Provider," and search for a provider in the network entitled "Delta Dental PPO" or call 1-800-236-3712.

** Any orthodontic out-of-pocket already met under the current Care Plus plan will be transferred to the Delta Dental EPO for continuation of this benefit coverage under this plan.

ROUTINE VISION COVERAGE

BENEFITS FOR ACTIVE EMPLOYEES ONLY

NATIONAL VISION ADMINISTRATORS (NVA)		
BENEFITS	FREQUENCY	Participating Provider Covered Amount In-Network Only
EXAM	Once Every 12 Months	Paid in Full
FRAMES	Once Every 12 Months	Up to $100 Retail Allowance (20% discount off balance)
LENSES (glass or plastic) Type: Single Vision Bifocal Trifocal Lenticular Standard Scratch Coating Polycarbonates (under age 19)	One Pair Every 12 Months	Paid in Full Covered 100% Covered 100%
CONTACT LENSES (in lieu of frames and lenses) Elective Fit/Follow-Up Standard Daily Wear Standard Extended Wear Specialty Wear Medically Necessary- Preapproval From NVA required	 Once Every 12 Months Once Every 12 Months	 Covered up to $100 Retail Allowance 15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $100 Covered 100% after $20 copay Covered 100% after $30 copay Covered 100% after $50 copay

As a member of NVA, you can access more information at www.e-nva.com***.***

APPENDIX C: MONTHLY PREMIUM COSTS (ALL PLANS)

Active Employee Rate Information

Total Monthly Premium (Health and Vision):
All rates effective January 1, 2020-December 31, 2020

HEALTH PLAN	PPO/Choice Plus	EPO Plan	HDHP
Single	$804.59	$832.59	$772.52
Family	$1,891.12	$1,956.93	$1,795.16

Employee insurance premium share is deducted from twenty (20) paychecks, for all employees, typically starting with the first paycheck in January 2020 through the first paycheck in June 2020. Deductions will resume with the first paycheck of September 2020 through the last paycheck in December 2020. There are no "make-up" contributions for 10-month employees, and 12-month employees do not pay any premium share in July and August.

Note: If a plan change or new enrollment occurs in the summer months, your premium share will be adjusted accordingly and will be taken with deductions resuming in September.

The charts below list the per-paycheck deduction and the annual percentage of premium contribution for each plan and salary band. As always, employee premium contributions are taken on a pre-tax basis.

Active Employee Per Paycheck Health and Vision Contribution:

Annual Base Salary		PPO %	PPO Employee Deduction	EPO%	EPO Employee Deduction	HDHP%	HDHP Employee Deduction
$25,000 or under	Single	11%	$53.10	5%	$24.98	2%	$9.27
	Family	11%	$124.81	5%	$58.71	2%	$21.54
$25,001 to $50,000	Single	12%	$57.93	8%	$39.96	5%	$23.18
	Family	12%	$136.16	8%	$93.93	5%	$53.85
$50,001 to $75,000	Single	13%	$62.76	10%	$49.96	7%	$32.45
	Family	13%	$147.51	10%	$117.42	7%	$75.40
$75,001 and above	Single	14%	$67.59	12%	$59.95	9%	$41.72
	Family	14%	$158.85	12%	$140.90	9%	$96.94

Dental Premiums for Active Employees

Dental Plan	Delta Dental PPO		Delta Dental EPO	
	Total Premium	Employee Per Paycheck Deduction	Total Premium	Employee Per Paycheck Deduction
Single	$27.51	$0.83	$31.32	$0.94
Family	$95.79	$2.87	$103.49	$3.10

Employee Premium Contributions – Additional Information
When the Department of Benefits, Pension & Compensation is notified in a timely manner of a Family Status Change (within 31 days), premium adjustments will be made via the employee's payroll. Late status change notices will not result in retroactive premium refunds. If you are granted an approved leave, including leaves under the Family Medical Leave Act (FMLA), you are still required to pay your employee premium contribution. If your FMLA is unpaid, your employee premium contribution will be put into arrears. These deductions will be applied to your next paycheck upon your return to work, or billed to you in full if you do not return to MPS at the end of your unpaid leave.

COBRA Coverage Rates

(Consolidated Omnibus Budget Reconciliation Act of 1985 Continuation Coverage)

All rates effective January 1, 2020-December 31, 2020

Health COBRA Rates:

HEALTH PLAN	PPO/Choice Plus	EPO Plan	HDHP
Active Employees Monthly COBRA Premium (includes Vision)			
Single	$820.68	$849.24	$787.97
Family	$1,928.94	$1,996.07	$1,831.06
Retiree Monthly COBRA Premium (excludes Vision)			
Single	$816.15	$844.71	$783.44
Family	$1,917.96	$1,985.08	$1,820.08
Couple, 1 w/ Medicare	$1,052.84	$1,081.40	$1,020.13
Family, 1 w/ Medicare	$1,338.50	$1,377.06	$1,273.34
Family, 2 w/ Medicare	$759.03	$769.03	$726.59

COBRA Medicare Only Rates:

HEALTH PLAN	Medicare Advantage
Single w/ Medicare	$236.69
Couple, 2 w/ Medicare	$473.38
Family, 3 w/Medicare	$710.07
Family, 4 w/Medicare	$946.76

Dental COBRA Rates:

Dental Plan	Delta Dental PPO	Delta Dental EPO
	Total Monthly Premium	Total Monthly Premium
Single	$28.06	$31.95
Family	$97.71	$105.56

APPENDIX D: FAMILY STATUS CHANGES/LIFE EVENTS

Note: An election change must satisfy the IRS requirement that it must be consistent with the change in status. Please complete a Benefits Application/Change Form for all health and dental insurance adds/changes other than terminating health or dental. Forms can be found on mConnect or in The Department of Benefits, Pension and Compensation Room 124, at Central Services.

****For terminating/canceling health and dental coverage complete a Benefits Termination Form found on mConnect or Central Services Room 124.**

Please see Flexible Spending Account (FSA) booklet for Healthcare and Dependent Care FSA Family Status Changes

Life Event (Effective date of change for health and dental will be the date of the life event unless otherwise noted.)	Health Insurance (Includes Vision Coverage)	Dental Insurance	Voluntary Life Insurance	Spouse/Child Life Insurance	Required Documentation For Health and Dental Changes	Enrollment Period
Marriage	Enroll yourself, spouse and eligible dependent children **Cancel your coverage if you enroll in your new spouse's coverage	Same as health	*Elect or increase up to the Guarantee Issue Amount.	*Elect or increase up to the Guarantee Issue Amount. Child life insurance can be elected for $5,000 or $10,000.	Marriage Certificate: Must be registered certified state copy. (Testament of marriage is not valid proof.)	Within 31 days of the event
Divorce/Annulment (effective the last day of the month)	Enroll yourself and eligible dependent children who lost coverage under your former spouse's plan **Cancel coverage for former spouse and any dependents of your former spouse	Same as health	*Elect or increase up to the Guarantee Issue Amount.	*Elect or increase up to the Guarantee Issue Amount. Child life insurance can be elected for $5,000 or $10,000. Cancel coverage for spouse.	Proof of loss of coverage - see "Loss of Health Coverage" **Notification of date of divorce.	Within 31 days of the event
Death of Spouse (effective the last day of the month)	Enroll yourself and eligible dependents who lost coverage under a spouse's plan **Cancel coverage for deceased spouse	Same as health	*Elect or increase up to the Guarantee Issue Amount.	*Elect or increase up to the Guarantee Issue Amount. Child life insurance can be elected for $5,000 or $10,000. Cancel coverage for spouse.	Proof of loss of coverage - see "Loss of Health Coverage" **Notification of date of death.	Within 31 days of the event
Birth or Adoption/Placement for Adoption	Enroll yourself, spouse and eligible dependent children **Cancel Coverage	Same as health	*Elect or increase up to the Guarantee Issue Amount.	*Elect or increase up to the Guarantee Issue Amount. Child life insurance can be elected for $5,000 or $10,000.	For birth of a child: birth certificate or notice of registration of birth. For adoption/placement: court adoption or adoption agency placement letter.	For health & dental: within 60 days of event; For life insurance: must be within 31 days of event.

***Evidence of Insurability is required if the benefit exceeds the Guarantee Issue Amount. To elect a change to a family status change/life event, please contact The Standard onsite account specialist at: 414-475-8699.**

Family Status Changes/Life Events (con't)

Note: An election change must satisfy the IRS requirement that it must be consistent with the change in status. Please complete a Benefits Application/Change Form for all health and dental insurance adds/changes other than terminating health or dental. Forms can be found on mConnect or in The Department of Benefits, Pension and Compensation Room 124, at Central Services.

****For terminating/canceling health and dental coverage complete a Benefits Termination Form found on mConnect or Central Services Room 124.**

Please see Flexible Spending Account (FSA) booklet for Healthcare and Dependent Care FSA Family Status Changes

Life Event (Effective date of change for health and dental will be the date of the life event unless otherwise noted.)	Health Insurance (Includes Vision Coverage)	Dental Insurance	Voluntary Life Insurance	Spouse/Child Life Insurance	Required Documentation For Health and Dental Changes	Enrollment Period
Change in Eligibility for Medicaid, Medicare or CHIP Coverage (cancellation of coverage would be effective last day of the month)	Enroll or change to family plan to add an eligible dependent upon loss of eligibility for Medicare or Medicaid **Cancel or change to a single plan if employee, spouse, or dependent becomes entitled to Medicare or Medicaid	Same as health	N/A	N/A	Proof of loss of Medicaid, Medicare, or CHIP coverage must be within 60 days of the change date. **Notification of Medicare/Medicaid/ CHIP cancellation or change date.	Within 60 day of the event
Death of Child (effective last day of the month)	**Cancel coverage of deceased child	Same as health	*Elect or increase up to the Guarantee Issue Amount.	*Elect or increase up to the Guarantee Issue Amount. Child life insurance can be elected for $5,000 or $10,000. Cancel coverage for child if only child covered.	**Notification of date of death.	Within 31 days of the event
Loss of Health Coverage	Enroll yourself, spouse and eligible dependents if coverage lost under a spouse's plan or other plan Enroll dependent child(ren) under age 26	Same as health	N/A	N/A	COBRA election notice, government notice on letterhead, HIPAA notice of coverage loss, letter from employer or insurance company. Also needed: marriage certificate for spouse (see marriage documentation above) and birth certificate for dependent children.	Within 31 days of the event; 60 days for the loss of Medicaid, Medicare or state CHIP

***Evidence of Insurability is required if the benefit exceeds the Guarantee Issue Amount. To elect a change to a family status change/life event, please contact The Standard onsite account specialist at: 414-475-8699.**

Family Status Changes/Life Events (con't)

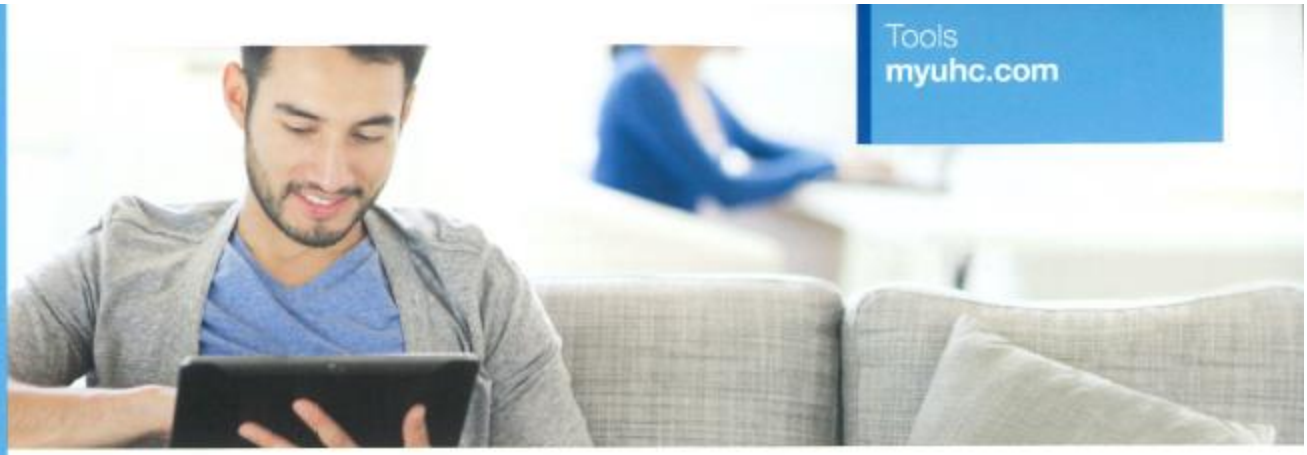
Note: An election change must satisfy the IRS requirement that it must be consistent with the change in status. Please complete a Benefits Application/Change Form for all health and dental insurance adds/changes other than terminating health or dental. Forms can be found on mConnect or in The Department of Benefits, Pension and Compensation Room 124, at Central Services.

****For terminating/canceling health and dental coverage complete a Benefits Termination Form found on mConnect or Central Services Room 124.**

Please see Flexible Spending Account (FSA) booklet for Healthcare and Dependent Care FSA Family Status Changes

Life Event (Effective date of change for health and dental will be the date of the life event unless otherwise noted.)	Health Insurance (Includes Vision Coverage)	Dental Insurance	Voluntary Life Insurance	Spouse/Child Life Insurance	Required Documentation For Health and Dental Changes	Enrollment Period
Judgments, Decrees, or Orders	Enroll or change to family plan to add an eligible dependent **Cancel coverage or change to single plan if order requires spouse or other individual to provide coverage	Same as health	N/A	N/A	Judgement, decree or court order	Within 31 days of the event
The Commencement or Termination of your Spouse's employment or Change in Employment from Benefit Eligible to Non-Benefit Eligible by your Spouse	For commencement or change to benefit eligible: cancel or change to single plan Enroll self, spouse and/or dependents if coverage lost under spouse's plan	Same as health	*Elect or increase up to the Guarantee Issue Amount.	*Elect or increase up to the Guarantee Issue Amount. Child life insurance can be elected for $5,000 or $10,000.	**Notification of change date Proof of loss of coverage - see "Loss of Health Coverage"	Within 31 days of the event
HIPAA Special Enrollment Rights - See page 32 for full description	See page 32 for full description	Same as health	Review this list of events as one may apply to your "special enrollment" reason	Review this list of events as one may apply to your "special enrollment" reason	Proof of loss, see Loss of Health Coverage, or proof of eligibility for state coverage	Within 60 days of event for Medicaid, state CHIP, and birth/adoption of a child; all other special enrollments must be within 31 days of the event

***Evidence of Insurability is required if the benefit exceeds the Guarantee Issue Amount. To elect a change to a family status change/life event, please contact The Standard onsite account specialist at: 414-475-8699.**



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myuhc.com® is your personalized member website to help you access and manage your medical, dental and vision plan information 24/7.*

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View 18 months of your claims history and easily see how your claim was processed, what your plan covered and what you may owe your provider. You can also access and submit claims forms and pay your provider directly through InstaMed®.

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UnitedHealthcare®

Employee Wellness Program

Take advantage of this important employee benefit! All programs are free of cost and voluntary!

At MPS, we believe that when our employees are healthy and happy, our students and our community thrive. That is why we are invested in the well-being of all MPS employees through the "Healthy You, Healthy Schools" employee wellness program. Healthy You, Healthy Schools offers a wide variety of individual and group programs to enhance your physical, emotional and professional well-being.

Learn more about wellness programs on mConnect at mpsmke.com/wellness.

For additional information, contact Veronica Bohannon at griffiv1@milwaukee.k12.wi.us.

Individual Program Offerings

The following programs are available based on your individual health and wellness goals.

- UHC programs include:
  - Asthma Disease Management
  - Cancer Resources Services
  - Congenital Heart Disease Resource Services
  - Kidney Resource Services
  - Healthy Pregnancy Program
  - Diabetes Condition Management
  - Coronary Artery Disease
- Healthy Contributions Gym Reimbursement
- Employee Assistance Program

Group Program Offerings

Wellness On-Site is a menu of physical, emotional, and professional wellness programming offered on site, at your work location, and at no cost to you!

- On-site Group Exercise
- Healthy Cooking Classes
- Adult Sports Leagues
- Financial Wellness
- Worksite Trainings
- Stress Management
- Team Challenges:
  - Physical Activity
  - Weight Loss
  - Team Building … *and much more!*

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HEALTHY SCHOOLS
Professional | Physical | Emotional