City of Waukesha

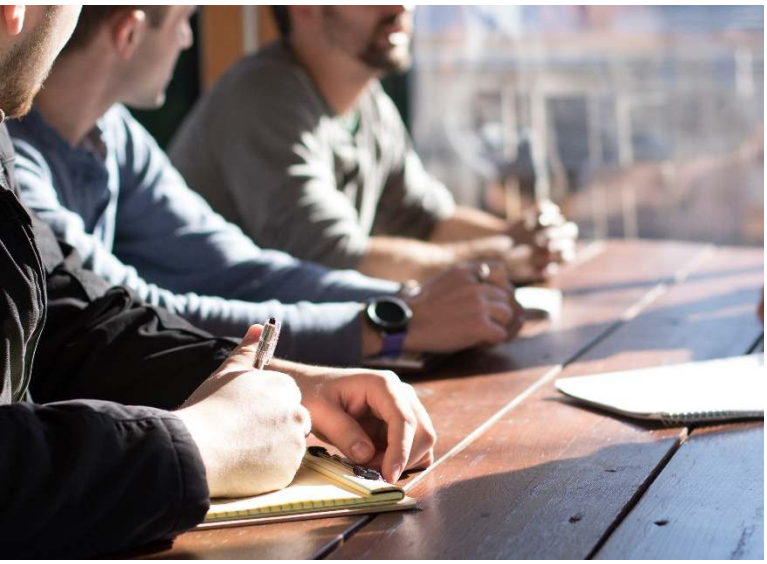
2024

EMPLOYEE BENEFITS GUIDE

Table of Contents

We encourage you to read the entire benefit guide before you enroll. This is a summary of benefits only. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to your Summary Plan Description, Certificate of Coverage or HR policy. If information in this summary differs from the Summary Plan Description, Certificate of Coverage or policy, the Summary Plan Description, Certificate of Coverage or policy is the ruling document.

Welcome To Your Benefits



Open Enrollment

Each year you have the opportunity to review your benefit options and make choices based upon your current life situation. This Benefits Guide will assist you in your benefits decisions. Open enrollment is generally held in the month of November. Additional communication will be sent to announce the timing, benefit changes and the enrollment process. All employees working minimum hours and electing coverage need to enroll in the plan offerings by completing the enrollment process.

When Coverage Begins And Ends

The benefit options you choose during this plan year are effective 1/1/2024 – 12/31/2024.

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Changing Benefit Elections

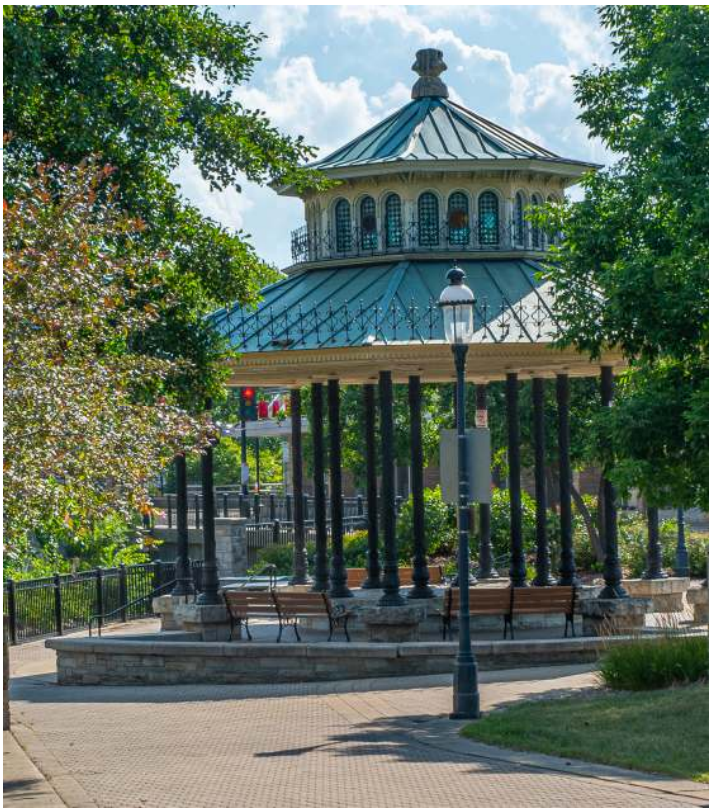
To protect the tax advantages of your benefits, the City of Waukesha is required to follow certain IRS rules. These rules affect when you may change your benefits and what changes you may make. **Notification must be made to HR within 30 days of the event.**

You may change your benefit elections mid-year for the following events:

- The addition of dependents due to the birth or adoption of a child
- Your marriage
- The death of one of your dependents
- A change in the employment status of your spouse or dependent, including the termination or commencement of employment, loss of work due to a strike or lockout
- Your dependent loses or gains benefit eligibility with an employer's benefit plan
- Your divorce, legal separation, annulment

City of Waukesha

Eligibility



If you are an employee working a minimum number of hours per week* you are eligible to sign up for benefits. Benefits are effective the first of the month following your date of hire, except for life insurance. Life insurance is effective first of the month following 30 days of hire. Your eligible dependents can enroll in some benefits as well. Eligible dependents include:

- Your legal spouse
- Dependent children up to the age of 26
- Your physically or mentally disabled children beyond age 26 if meeting specific criteria established by insurance company

The chart below provides an overview of the basic benefits and optional coverages offered to you and your eligible dependents.

Benefit	Carrier	Coverage Levels	Employee Cost Sharing
Medical **Prescription Drug** **Virtual Services**	UMR Serve You Rx Teladoc	Employee & Family	Cost sharing between the City and employee for PP01; No cost to employee for PP02
Waukesha Employee Health & Wellness Center	Everside	Employee & Family* (*over age 2 years)	No cost for employees enrolled in the UMR health insurance except prescription co-pay of $2.00 paid by employee
Dental	Delta Dental	Employee & Family	Cost sharing between the City and employee for EPO; No cost to employee for PPO
Vision	National Vision Administrators (NVA)	Employee & Family	Cost paid by employee
Flexible Spending Account (FSA)	Diversified Benefits Services	Employee & Family	Accounts are funded by employee for FSA
Health Reimbursement Account	Diversified Benefits Services	Employee & Family	Accounts are funded by the City for the HRA Employee must be enrolled in PPO2 health plan and complete the health risk assessment

*40 hours for dental insurance, 30 hours for health insurance and FSA, 23 hours for life insurance and 20 hours for all other benefits

Eligibility (cont.)

Benefit	Carrier	Coverage Levels	Employee Cost Sharing
Basic term life insurance	WI Department of Employee Trust Funds	Employee	Cost is paid by the city
Supplemental, additional & dependent life insurance	WI Department of Employee Trust Funds	Employee & spouse/dependents	Cost is paid by the employee
Short term disability & Long term disability	Symetra	Employee	Cost is paid by the employee
Employee Assistance Program	FEI	All employees & spouse/dependents	Cost is paid by the City
Retirement	Wisconsin Retirement System	Employee	Account is funded by City and employee percent, per State statute
457 (b) Deferred Compensation	Met Life, Mutual of America, ICMA or Wisconsin Deferred Compensation	Employee	Account is funded by employee
Accident/sickness Insurance	AFLAC	Employee	Cost is paid by employee; Employees on PPO2 Health will receive $50 per month towards Aflac
FICA Alternative Program	MidAmerica	Temporary, seasonal & part-time employees	7.5% required employee only contribution

Health Insurance

Our health insurance plan is self-funded and administered by UMR. It is available for employees working 30 or more hours per week. You can find network providers and tools for comparing healthcare costs by logging in to www.umr.com or by calling: 1-800-207-3172. For questions on pharmacy coverage, contact log on to www.serve-you-rx.com or call 1-800-759-3203.

2024 Health Insurance Plan Summary (See Summary of Coverages or SPD for more information)

Plan Detail	PPO 1	PPO1	PPO 2	PPO 2
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible*	$750 for single $1,250 for family	$1,600 for single $2,950 for family	$1,450 for single $2,650 for family	$2,550 for single $4,850 for family
City's contribution to a Health Reimbursement Account (HRA)**	NA	NA	$550 for single $1,100 for family Employee pays the first $550 of in-network deductible	$550 for single $1,100 for family Employee pays the first $550 of in-network deductible
Co-Insurance (plan pays)	80%	60%	80%	60%
Out-of-Pocket Maximum***	$1,100 for single $1,950 for family	$2,450 for single $4,650 for family	$2,950 for single $5,650 for family	$5,550 for single $10,850 for family
Preventative Care	$0 (deductible waived)	Not Covered	$0 (deductible waived)	Not Covered
Office Visit Copay	$35 copay w/HRA $50 copay w/o HRA	Deductible + Coinsurance (20%)	$35 copay + Coinsurance (20%)	Deductible + Coinsurance (40%)
Physical, Occupational & Speech Therapy	$35 copay w/HRA $50 copay w/o HRA	Deductible + Coinsurance (40%)	Deductible + Coinsurance (20%)	Deductible + Coinsurance (40%)
Lab and X-ray	20%	Deductible + Coinsurance (40%)	Deductible + Coinsurance (20%)	Deductible + Coinsurance (40%)
Teladoc – Virtual General Care or Behavioral Health	$0 (deductible waived)	NA	$0 (deductible waived)	NA
Teladoc – Virtual Dermatology Care	$20 copay	NA	$20 copay	NA
Emergency Care	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)	$100 copay + Coinsurance	$100 copay + Coinsurance (40%)
Inpatient Services	$100 copay + Deductible + Coinsurance (20%)	$100 copay + Deductible + Coinsurance (40%)	Deductible + Coinsurance (20%)	Deductible + Coinsurance (40%)
Outpatient Hospital Services	Deductible + Coinsurance (20%)	Deductible + Coinsurance (40%)	Deductible + Coinsurance (20%)	Deductible + Coinsurance (40%)

*Deductible applies to all services in PPO 1 unless otherwise noted in plan documents. (Deductible does not apply to drugs)

** City's contribution to a Health Reimbursement Account (HRA) – employee and eligible spouse (where applicable) must complete health risk assessment to be eligible for deductible reimbursement

***Out-of-Pocket Maximum includes deductible, copays and coinsurance. (Prescription coverage has separate out-of-pocket maximum)

Teladoc Virtual Services

General Medicine: $0 Copay

Talk to a U.S. – licensed doctor for non-emergency conditions 24/7 from anywhere you are. Teladoc providers can even send necessary prescriptions to your pharmacy of choice when appropriate. Services include:

- Bronchitis
- Pink Eye
- Flu
- Sinus Infections
- Sore throats
- And more

Dermatology Medicine: $20 Copay

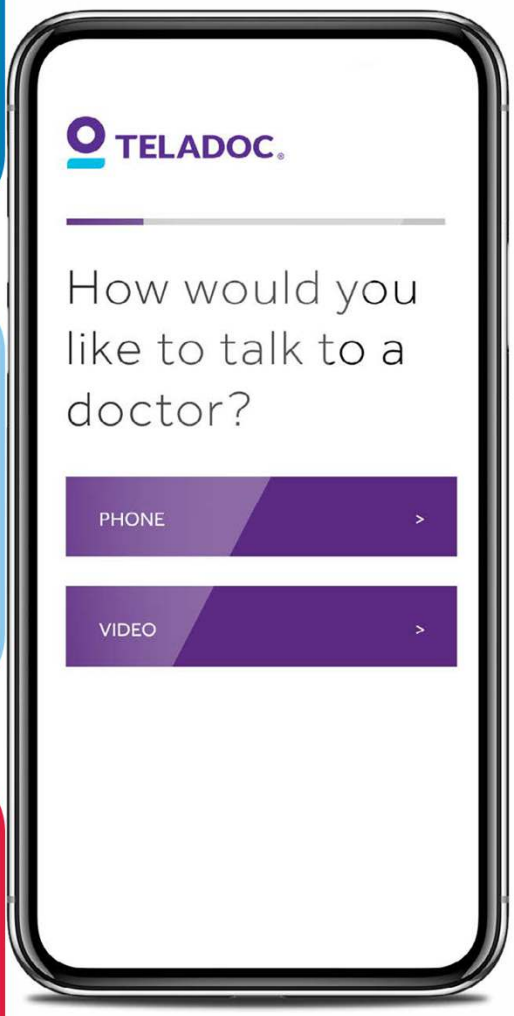
Upload images of a skin issue online or on the app and get a custom treatment plan within two days. Services include treatment of:

- Acne
- Eczema
- Raised moles
- Rashes
- Rosacea
- And more

Mental Health Care: $0 Copay

Talk to a therapist or psychiatrist seven days a week (7 a.m. to 9 p.m.) from wherever you are. Appointments are scheduled for your convenience. Services include treatment for:

- Anxiety
- Depression
- Not feeling like yourself
- Marital issues
- Stress
- And more



Get started today

Download the app | Visit Teladoc.com | Call 1-800-835-2362

City of Waukesha

Health Insurance

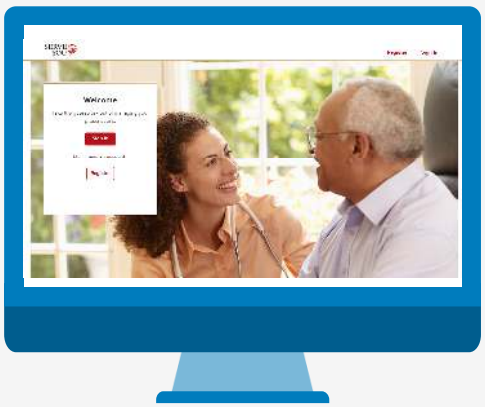
Our health insurance plan is self-funded and administered by UMR. It is available for employees working 30 or more hours per week. You can find network providers and tools for comparing healthcare costs by logging in to www.umr.com or by calling: 1-800-207-3172. For questions on pharmacy coverage, contact log on to www.serve-you-rx.com or call 1-800-759-3203.

Prescription Drug Copay		
Plan Detail	**PPO 1**	**PPO 2**
	In-Network	**Out-of-Network**
Out-of-Pocket Maximum*	$6,150 for single $12,300 for family	$4,350 for single $8,700 for family
Retail, 31-day supply	$10 Generic $30 Brand $50 Non-Formulary	$10 Generic $30 Brand $50 Non-Formulary
Mail order, 90-day supply	$25 Generic $75 Brand $125 Non-Formulary	$25 Generic $75 Brand $125 Non-Formulary
Specialty Drugs, 31-day supply	$150 Specialty	$150 Specialty

*Out-of-Pocket Maximum includes Rx copays. (Medical coverage has separate out-of-pocket maximum)

Additional Pharmacy Program Information:

- Maintenance Medications must be filled at DirectRx Mail Order Pharmacy after two Retail fills
- Preferred Drug List: Select Formulary
- Step Therapy Program: Included



Log on to the member portal at www.serve-you-rx.com or call a representative at 1-800-759-3203 for:

- ✓ Select formulary drug list
- ✓ Step therapy program drug list
- ✓ DirectRx Mail forms and refill information
- ✓ Cost comparison tools
- ✓ And more!

Deductible Reimbursement

Deductible Reimbursement – Health Reimbursement Arrangement (HRA) – PPO 2 Plan Only

If you elect PPO 2 coverage but do not complete a health risk assessment you are not eligible for deductible reimbursement.

If you have **single** coverage: You are responsible for the first $550 of the $1,450 in-network deductible. The City of Waukesha will reimburse you $550 of the deductible if you incur this amount in claims. You are responsible for the remaining $350 of the $1,450 deductible.

If you have **family** coverage: You are responsible for the first $550 of the $2,650 deductible. The City of Waukesha will reimburse you the next $550 of the $2,650 deductible. You are responsible for the next $550 of the $2,650 deductible. The City will then reimburse an additional $550 of the $2,650 deductible if you incur this amount in claims. You are responsible for the remaining $450 of the $2,650 deductible.

Plan Administration – How it works

- The health reimbursement arrangement (HRA) is administered by Diversified Benefit Services (DBS).
- As you receive healthcare services, submit all your explanation of benefits (EOB) to DBS. They will track your usage of deductible and reimburse you after you have paid your portion as described above.
- Claim forms are available in HR and at www.dbsbenefits.com.
- Claims can be submitted by mail, fax or uploaded in an electronic/scanned file. You may also contact DBS by phone at 1- 800-234-1229.
- At the end of each Plan Year you have a 90-day run-out period in which you may submit your claims.
- If you terminate employment, you have a 60-day run-out period in which you may submit your claims

City of Waukesha

Opt-out Incentive – Health Insurance Wellness Center

For those eligible for health insurance but waive coverage an opt-out incentive for health insurance is available. HR must have a signed waiver of health insurance on file to pay out the opt-out. The opt out incentive would be paid out beginning on the date of eligibility.

2024 amounts for 26 payments:	**If eligible for Family Health - $100.00 per pay check period**
	If eligible for Single Health - $35.00 per pay check period

Waukesha Employee Health And Wellness Center

The Waukesha Employee Health & Wellness Center, operated by Everside, serves the City of Waukesha, providing convenient and affordable access to health care. Staffed with a Board-Certified physician, Board Certified physician assistants, Board Certified health and wellness coaches and physical therapists, the Health & Wellness Center offers acute care, preventive care, chronic condition management, physical therapy and occupational health services. Visit the Waukesha Employee Health and Wellness Center website: https://sites.google.com/site/wehwc3/

Toll-free scheduling line: 1-866-959-9355

Eligibility – The Waukesha Employee Health & Wellness Clinic is open to:

- Employees enrolled in the City's UMR health insurance plan
- Pre-Medicare/Active retirees enrolled in the City's UMR health insurance plan
- Dependents, including spouses and children over the age of 2, who are enrolled in the City's UMR health insurance plan

All City employees are eligible for worker's compensation services provided in the clinic.

Services – The Waukesha Employee Health & Wellness Center provides the following **NO COST*** services, not limited to:

Disease Management

- Manage Diabetes
- Cholesterol
- Blood pressure

Minor Injuries

- Muscle and join pain
- Sprains and stains
- Cuts and stitches

Lifestyle Coaching/Health Coaching

- Tobacco cessation
- Weight loss

Work Related Injuries and Occupational Health

Preventative Services

- Routine annual physical exam (ages 6+)
- Vision screening
- Flu shot
- Tetanus

Acute Illness

- Sore throat
- Ear infections
- Sinus infections
- Cold, flu, etc.
- Allergy care

Physical Therapy

Medication

- Dispense pre-packaged medication from formulary, where available (*$2.00 copay per RX)

Lab Work and Vaccinations

- Administer shots/vaccinations
- Order, conduct, interpret and consult on routine diagnostic lab work

Referral to Specialists

Dental Insurance

Our group dental plan is with Delta Dental and available for employees working 40 or more hours per week. Dental plan benefits will depend on the option you choose. Find a provider by calling 1-800-236-3712 or visit www.deltadentalwi.com.

Option 1 – Preferred Provider (PPO) Plan

Delta Dental PPO Dentists: Delta Dental PPO dentists agree to accept payment based on a reduced schedule, which means your out- of-pocket costs will be less.

Delta Dental Premier Dentists: Delta Dental Premier Dentists have signed a contract with Delta Dental, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge you any amount that exceeds the Maximum Plan Allowance. **Noncontract Dentists:** If your dentist has not signed a contract with Delta Dental, claim payments will be calculated on Delta's plan allowance, but they will be sent directly to the employee, rather than your dentist. You will need to reimburse your dentist.

Option 2 – Exclusive Provider (EPO) Plan

Delta Dental PPO Dentists: Delta Dental PPO dentists agree to accept payment based on a reduced schedule, which means your out- of-pocket costs will be less. Employees must use a PPO provider or they will not receive the insurance benefit.

Benefit Plan Design	Dental PPO – Option 1 PPO	Delta Premier – Option 1 PPO	Delta PPO – Option 2 EPO
Individual Annual Maximum	$1,000	$1,000	Unlimited
Deductible	Single: $25 Family: $75 Ortho Deductible: $0	Single: $25 Family: $75 Ortho Deductible: $0	Single: $0 Family: $0 Ortho Deductible: $650
Diagnostic & Preventative Services Includes exams, cleanings, fluoride treatments*, x-rays, space maintainers, sealants*, and emergency treatment for pain	100%	100%	100%
Basic & Major Services			
Fillings	100%	100%	100%
Endodontics	80%	80%	100%
Periodontics	80%	80%	100%
Extractions	80%	80%	100%
Crowns, inlays, onlays	50%	50%	70%
Bridges and dentures	50%	50%	70%
Implants	50%	50%	70%
Deductible applies	Yes	Yes	No
Orthodontic Services			
Coverage copayment	50%	50%	100%
Individual lifetime max	$1,500	$1,500	Unlimited
Dependents eligible to age	19	19	25
Full-time student eligible	19	19	25
Adult ortho	No	No	Yes
Deductible applies	No	No	Yes

*Subject to age limits. See SPD for more information

Vision Insurance

Our group vision plan is with National Vision Administrators (NVA) and available for employees working 20 or more hours per week. This vision insurance plan is a 'materials only' plan and doesn't cover an annual eye exam. Where enrolled, an eye exam is covered under the group health plan with UMR. To find a provider call 1-800-672-7723 or visit www.e-nva.com.

Benefit Plan Design	In-Network	Out-of-Network
Services/Frequency Frames Lenses Contact Lenses	 24 months 12 months 12 months	 24 months 12 months 12 months
Frames	$125 retail allowance	Up to $70 retail
Lenses (standard per pair) Single Vision Bifocal Trifocal Progressive Lenticular	 Covered in full Covered in full Covered in full See Description* Covered in full	 Up to $25 retail Up to $40 retail Up to $45 retail Up to $50 retail Up to $80 retail
Contact Lenses** Contact Lens Fitting – Standard Daily Wear Contact Lens Fitting – Standard Extended Wear Contact Lens Fitting – Specialty Wear	$150 retail allowance $20 copay $30 copay $50 copay	Up to $125 retail Up to $20 Up to $30 Up to $50
Medically necessary contact lenses	Covered in full	Up to $150 retail

*Covered to provider's in-office standard retail lined trifocal amount; member pays the difference between progressive and standard retail lined trifocal, plus $50

**Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit

Plan Rates

HEALTH

Coverage Level	Employee Cost per Month	Employee Cost Bi-Weekly
PPO 1 – Single w/HRA*	$99.07	$45.72
PPO 1 – Family w/HRA*	$310.02	$143.09
PPO 1 – Single w/out HRA**	$165.11	$76.20
PPO 1 – Family w/out HRA**	$516.71	$238.48
PPO 2 – Single	$0.00	$0.00
PPO 2 – Family	$0.00	$0.00

*Employee and eligible spouse (where applicable) complete the Health Risk Assessment (HRA), employee pays 12% of the health insurance premium

**Employee and eligible spouse (where applicable) do not complete the HRA, employee pays 20% of the health insurance premium and higher office visit copays

Enrolling Dependents – Employee must provide copies of marriage license, birth certificate(s) and social security cards for all dependents enrolled in the health plan when enrolling.

DENTAL

Coverage Level	Employee Cost per Month	Employee Cost Bi-Weekly
PPO – Single	$0.00	$0.00
PPO – Family	$0.00	$0.00
EPO – Single	$51.31	$23.68
EPO – Family	$177.55	$81.95

VISION

Coverage Level	Employee Cost Bi-Weekly
Employee Only	$2.08
Employee + Limited Family (Spouse OR Children)	$4.16
Employee + Family	$5.51

Flexible Spending Accounts

Flexible Spending Accounts (FSA) allow eligible employees to set aside money to pay for eligible expenses with tax-free dollars. The spending accounts offer significant tax advantages because you don't pay Social Security, Federal or State taxes on the portion of your income that you contribute to your spending account. Each plan year beginning on January 1st, you can make an annual election to contribute to these accounts. The FSA accounts are administered by Diversified Benefits Services (www.dbsbenefits.com). For questions regarding the plan or assistance in filing a claim, you can contact DBS at (800) 234-1229.

Healthcare Flexible Spending Account: Use this account to cover the cost of health, dental, vision and hearing expenses which are not covered under an insurance plan for you and your dependents which are considered eligible healthcare FSA expenses. You may contribute up to $3,200 per year (subject to change by IRS). Up to $640 in unused funds can rollover into the following plan year.

Dependent Care Spending Account: Use this account to cover the cost of licensed dependent care while you work. You may use this for expenses for the care of a child under age 13 or a disabled spouse, child or parent. If you are married, your spouse must be employed or attending classes full time for you to use the Dependent Care Spending Account. You may contribute up to $5,000 per year per household to this account or $2,500 per year if you are married and file your taxes separately.

How to Submit a Claim: You can choose one of 3 easy and secure methods to file your claim.

Mail/Fax:

Download a claim form (available in HR and at www.dbsbenefits.com). Complete the form and attach copies of your documentation and mail to Diversified Benefit Services, P.O. Box 260, Hartland, WI 53029 or fax to (262) 367-5938.

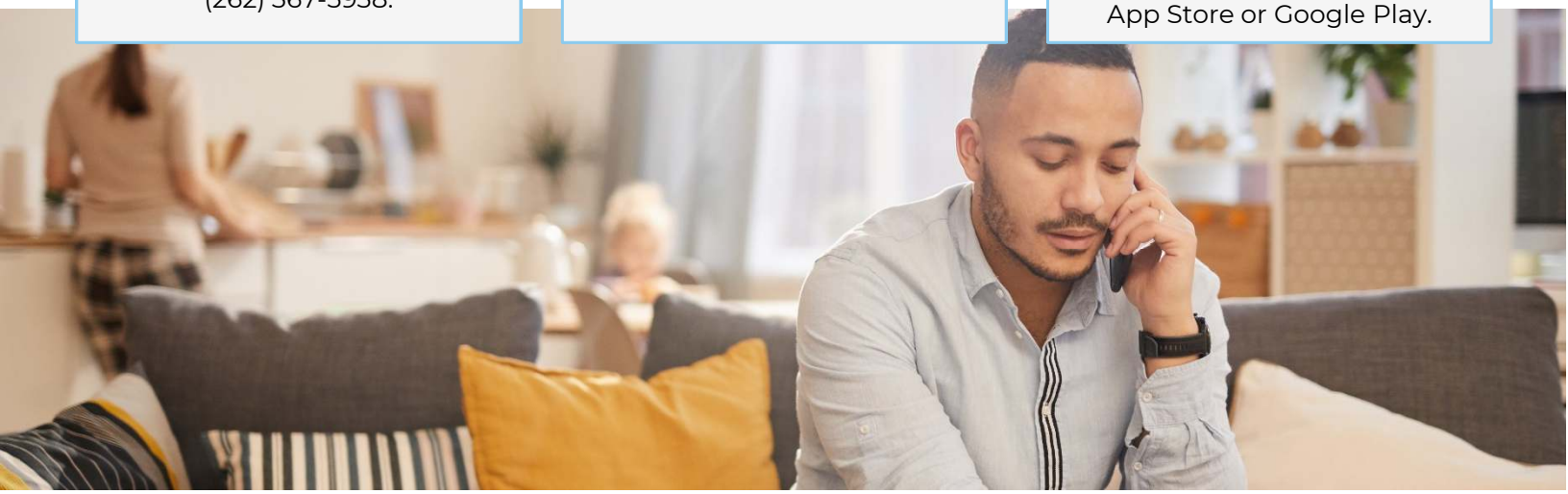
Online:

Login to your account at www.dbsbenefits.com, Select Benefit Plan Type, Select Claims on the top menu bar, select Claims > Submit, and follow directions to upload your supporting documentation.

Mobile App:

Login using your A.S.A.P.® name and password, select "File a Claim", and follow directions to upload image(s) of your supporting documentation.

The Diversified Benefit Services app is available via the Apple App Store or Google Play.



Note: At the end of each Plan Year you have a 90-day run-out period in which you may submit your claims. If you terminate employment, you have a 60-day run-out period in which you may submit your claims.

Life Insurance Benefits

Wisconsin Public Employers Group Life Insurance Program – WI Dept. of Employee Trust Funds

Basic Life Insurance: The City provides basic life insurance equal to one times the annual salary, rounded up to the nearest $1,000. Basic life is provided at no cost to eligible employees. Employees must work more than 23 hours per week to be eligible.

Supplemental Life Insurance: Employee has the option to elect supplemental life insurance up to 1x earnings, rounded up to the nearest $1,000. Monthly employee paid premium rates are based per $1,000 of insurance coverage, age of employee and associated amount below.

Additional Life Insurance: Employee has the option to elect additional life insurance up to 3x earnings, rounded up to the nearest $1,000. Monthly employee paid premium rates are based per $1,000 of insurance coverage, age of employee and associated amount below.

Spouse and Dependent Life Insurance: Employee has the option to elect either 1 Unit (Spouse =$10,000; Dependent= $5,000) or 2 Units (Spouse=$20,000; Dependent=$10,000) of life insurance coverage for spouse and dependents. Rates for each unit of spouse and dependent insurance is $1.75 per month.

The life insurance policy is administered through the Minnesota Life Insurance Company.

Wisconsin Public Employers Group Life Insurance Plan
Monthly Employee Premium Rates
Per $1,000 of Insurance

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

	State Employee		Local Government Employee
	Basic and Supplemental	Additional	Basic, Supplemental and Additional
Age	**April 1, 2023 – March 31, 2024**		**July 1, 2023 – June 30, 2024**
Under 30	$.05	$.08	$.05
30-34	$.05	$.08	$.06
35-39	$.05	$.08	$.07
40-44	$.08	$.11	$.08
45-49	$.13	$.19	$.12
50-54	$.20	$.31	$.22
55 - 59	$.28	$.42	$.39
60-64	$.38	$.57	$.49
65-69*	$.50	$.73	$.57
70 and older	**	**	**

State employees: Each Unit of Spouse and Dependent Insurance is $2.26 per month.

Local government employees: Each Unit of Spouse and Dependent Insurance is $1.60 per month.

*Premiums for age 65-69 are required as long as employment continues.

**Active employees aged 70 and older should contact HR for premium amounts.

Disability Benefits

Short Term Disability Insurance – Symetra

Eligible employees working 20 hours or more per week would need to elect and pay for short term disability coverage. The benefit amount is 60% of your weekly pay (maximum of $1,500 per week) and begins after a 14-day disability period (sick time can be used for this 14 day period, but not during the Short Term Disability payment period. Short Term Disability will continue as long as you are disabled for a maximum of 90 days and then coverage will transition to Long Term Disability mentioned below, if elected.

There is a pre-existing condition clause that will look back 3 months prior to enrollment for any prior health conditions to determine if you qualify for a benefit in the first 12 months.

Symetra Life Insurance Company: 1-800-833-6388

To determine your cost for coverage, please determine your monthly rate based on your weekly pay; use the following formula(s) to calculate your Bi-Weekly cost:

_____ / 52 = _____ / 10 = $ _____ x .6 (60%) = $ ____ x .285 = $ _____ x 12 = $ _____ / 26 = $ _____

Annual Salary (Max $1,500) My Bi-Weekly Cost

Long Term Disability (LTD) Insurance – Symetra

Eligible employees working 20 hours or more per week would need to elect and pay for long term disability coverage. The benefit amount is 60% of your monthly pay (maximum of $5,000 per month) and begins after a 90-day disability period. The maximum payment duration is to Social Security Normal Retirement Age, SSNARA, the age in which you are eligible for Social Security full retirement benefits.

Symetra Life Insurance Company: 1-800-833-6388

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.08	$0.08	$0.12	$0.21	$0.31	$0.45	$0.70	$0.95	$0.96	$0.89	$1.57	$1.92

To determine your cost for coverage, please determine your monthly rate based on your above age effective on the last March 1st, and then use the following formula(s) to calculate your Bi-Weekly cost:

_____ / 12 = _____ / 100 = $ _____ x $ ____ = $ _____ x 12 = $ _____ / 26 = $ _____

Annual Salary (Max $8,333.33) Rate My Bi-Weekly Cost

Employee Assistance Program (EAP)

The City of Waukesha has partnered with FEI Behavioral Health, a well-known and respected provider of EAP and Work-Life services. FEI has a network of counselors, located across the country, to provide these services to you and your family when you need them. FEI provides a confidential Employee Assistance Program (EAP) benefit at no cost to you. Whether it's relationship problems or emotional stress, your EAP connects you and your eligible family members with 24/7 phone access to live, professional counselors who can refer you to counseling sessions near your work or home.

Help through our EAP and Work-Life Services is:

- Professional—You have access to highly skilled, licensed, professional counselors and work-life specialists at no cost to you.
- Convenient—Counselors with flexible hours are available near your home or workplace. Referrals for work-life services are also made to local resources.
- Confidential—Your right to privacy is fully protected by law and company policy. No one at work or outside of work will know if you use the EAP and/or Work-Life Services.

Retirement Plans/FICA Alternative Program

457(b) Plans through various vendors

City of Waukesha employees are eligible to make a pre-tax elective deferral from their salary to the various 457(b) plans with a multitude of vendors. Most plans also permit after-tax Roth contributions, and such elective deferrals may be designated as Roth contributions.

Available vendors for 457(b) plans are:

- Mass Mutual (formerly MetLife)
- Mutual of America
- ICMA
- Wisconsin Deferred Compensation

See Human Resources for packets and enrollment information.

Wisconsin Retirement System (WRS):

The Department of Employee Trust Funds administers a number of benefit programs available through Wisconsin public employers.

Participation is based on the eligibility laws and statutes in force at the time of hire. There may be criteria that employees need to meet prior to participating in the WRS. Each situation is unique and requires research beyond what is stated here.

Employees who meet the eligibility criteria must be enrolled in the WRS. The employee has no choice unless the employee is a WRS annuitant upon hire. Employees contribute a certain percent each paycheck and the City matches that amount. The contribution level may change year to year and is set by the WRS.

Employees who do not meet the eligibility criteria may not be enrolled in the WRS.

FICA ALTERNATIVE PROGRAM

Temporary, seasonal and part-time employees must participate in the City's FICA alternative plan with MidAmerica. Participating employees contribute 7.5% of their pre-tax compensation to an individual 457(b) defined retirement annuity account. Your funds are invested in a group annuity contract with ING.

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AFLAC/Sick Leave

AFLAC

The City of Waukesha allows payroll deductions for voluntary insurance programs through Aflac. Voluntary insurance works hand in hand with major medical plans to help ensure individuals who are sick or hurt have the funds needed to pay health-related costs their primary insurance might not cover, as well as other out-of-pocket costs. Employees on the PPO2 Health Insurance option will receive $50 per month towards Aflac programs.

Aflac Representative Jenny Davies: 262-308-7274 or jenny_davies@us.aflac.com.

SICK LEAVE

All regular full-time and regular part-time (prorated benefits) employees are eligible to receive sick leave.

Sick leave with pay shall accrue to all regular full-time employees at the rate of one day (8 hours) for each full month of service and is credited to the employee on the 15th day of the month. Sick leave is pro-rated for regular part-time employees.

Unused sick leave shall accumulate from year to year to maximum of one hundred and twenty-five (125) work days (1000 hours).

To view the general guidelines and for more information please see Human Resources Policy C3 Leaves of Absence: https://tinyurl.com/yeyk8bmf.

Police and Fire Department bargaining unit employees see your labor agreement for more information.

Holidays and Vacation

Holidays

The City recognizes the following yearly holidays for regular full-time and regular part-time employees:

- New Years Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Day before Christmas Day
- Christmas Day
- Day before New Years Day
- Two (2) Floating Holidays

Holiday pay for regular full-time employees shall consist of eight (8) hours. Holiday pay is pro-rated for regular part-time employees. For more information please see Human Resources Policy C-1 Holidays: https://tinyurl.com/398j96c9 .

Police and Fire Department bargaining unit employees see your labor agreement for more information.

Vacation

Years of Continuous Service	8 hr. Personnel
Hire date through third (3rd) year of continuous service	10 hours accumulated per month (15 days per calendar year)
After three (3) years' service	10.67 hours accumulated per month (16 days per calendar year)
After six (6) years' service	12 hours accumulated per month (18 days per calendar year)
After nine (9) years' service	13.33 hours accumulated per month (20 days per calendar year)
After twelve (12) years' service	14 hours accumulated per month (21 days per calendar year)
After fifteen (15) years' service	14.67 hours accumulated per month (22 days per calendar year)
After eighteen (18) years' service	15.33 hours accumulated per month (23 days per calendar year)
After twenty (20) years' service	16 hours accumulated per month (24 days per calendar year)
After twenty-one (21) years' service	16.67 hours accumulated per month (25 days per calendar year)
After twenty-two (22) years' service	17.33 hours accumulated per month (26 days per calendar year)
After twenty-three (23) years' service	18 hours accumulated per month (27 days per calendar year)

To view the full vacation leave schedule, general guidelines and for more information please see Human Resources Policy C-2 Vacation Leave: https://tinyurl.com/3cmv5uvw.

Police and Fire Department bargaining unit employees see your labor agreement for more information.

Notices

WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

There are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

SPECIAL ENROLLMENT RIGHTS

Our records show that you are eligible to participate in the company's Group Health Plan (to participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

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 towards your or your dependents' other coverage). However, you must request enrollment within 30 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 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact Human Resources at 262-524-3745.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."
- 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 HUHS plan and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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: City of Waukesha Human Resources Department.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

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're eligible for health coverage from your employer, your state 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 aren't eligible for Medicaid or CHIP, you won't 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 a State listed below, contact your State 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, 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, ask your 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 allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at **www.askebsa.dol.gov** or call **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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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
Error! Hyperlink reference not valid.1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Notice Of Rights Under The Women's Health And Cancer Rights Act Of 1998

On October 21, 1998, the federal government enacted the Women's Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy.

This memo is intended to provide participants and beneficiaries with notice of their rights under the Women's Health and Cancer Rights Act Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient.

Such coverage includes:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

Please contact the Human Resources Department or the City's health insurance carrier directly for more information on your rights under the Women's Health and Cancer Rights Act.

New Health Insurance Marketplace Coverage Options And Your Health Coverage

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name CITY OF WAUKESHA			4. Employer Identification Number (EIN) 39-6005642
5. Employer address 201 DELAFIELD ST			6. **Employer phone number** 262-524-3745
7. **City** WAUKESHA		8. **State** WI	9. ZIP **code** 53186
10. Who can we contact about employee health coverage at this job? HUMAN RESOURCES			
11. Phone number (if different from above)	12. Email address HR@WAUKESHA-WI.GOV		

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    FULL-TIME ELIGIBLE EMPLOYEES; THEIR LEGAL SPOUSE AND DEPENDENT CHILDREN
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    ELIGIBLE EMPLOYEES' LEGAL SPOUSE AND DEPENDENT CHILDREN. DEPENDENT CHILDREN CAN BE COVERED UP TO THE AGE OF 26; TOTALLY DISABLED CHILDREN OVER AGE 26 CAN REMAIN COVERED PENDING MEETING SPECIFIED CRITERIA IN SUMMARY PLAN DESCRIPTION (SPD)
  - ☐ 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notice of Privacy Practices

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

The City of Waukesha (the "Plan") provides health benefits to eligible employees of **the City of Waukesha** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information.

To receive a copy of the Plan's Notice of Privacy Practices you should contact Human Resources by calling (262) 524-3745 or via e-mail at hr@waukesha-wi.gov. Alternatively, you can access City Policy C-10 – HIPAA Privacy Policy and Procedures for Group Health Insurance at http://www.waukesha-wi.gov/DocumentCenter/View/943 regarding the Plan's privacy practices and covered individuals' privacy rights. If you have questions or issues, please contact Human Resources.

The City is required by law to provide this notice to plan participants every three years.

City of
Waukesha

2024