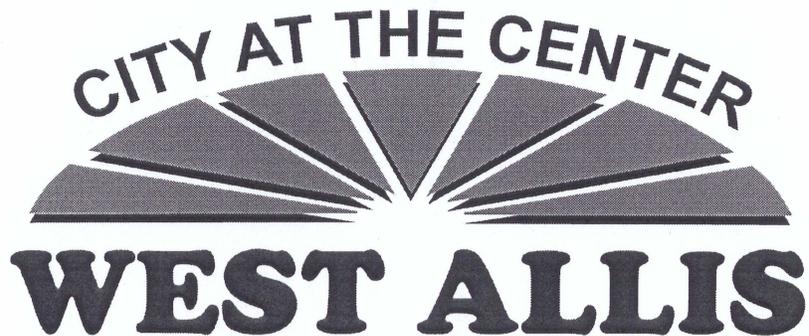


**2016**  
**EMPLOYEE INSURANCE**  
**OPEN ENROLLMENT**

**For Plan Year**  
**March 1, 2016 through February 28, 2017**



**Human Resources Department**  
*...benefitting others*

**City Hall**  
**7525 W. Greenfield Ave.**  
**West Allis, WI 53214**  
**(414) 302-8270**  
**[www.westalliswi.gov](http://www.westalliswi.gov)**

## TELEPHONE NUMBERS AND WEBSITES

If you have questions, contact the following organizations by phone or obtain information through their websites. If you are unable to resolve your situation, contact Jane Barwick of the Human Resources Department at 414-302-8272, Monday-Friday, 7:30 A.M. to 4:00 P.M. or by email, [jbarwick@westalliswi.gov](mailto:jbarwick@westalliswi.gov).

<b>Human Resources Department</b>	414-302-8270	<a href="http://www.westalliswi.gov">www.westalliswi.gov</a>
<b>Anthem Medical Plans</b> <ul style="list-style-type: none"> <li>• Claims/benefits/eligibility</li> <li>• Precertification</li> <li>• New card requests</li> <li>• Provider participation</li> <li>• Pharmacy/prescription drugs</li> </ul> M – F, 8 AM – 7 PM EASTERN	844-286-6371	<a href="http://www.anthem.com">www.anthem.com</a>
<b>Anthem’s Express Scripts (ESI) Pharmacy (including Mail Order)</b> M – F, 8 AM – 7 PM EASTERN	844-286-6371	<a href="http://www.anthem.com">www.anthem.com</a>
<b>Anthem’s Accredo Specialty Pharmacy (specialty medications only)</b> M – F, 8 AM – 11 PM EASTERN SAT, 8 AM – 5 PM EASTERN	800-870-6419  Fax (Doctor’s Only): 800-824-2642	<a href="http://www.anthem.com">www.anthem.com</a>
<b>Anthem Standard Dental Plan</b> <ul style="list-style-type: none"> <li>• Claims/benefits</li> <li>• New card requests</li> </ul> M - F, 7 AM - 7 PM CENTRAL	877-567-1805	<a href="http://www.anthem.com">www.anthem.com</a>
<b>Care Plus Dental Plan</b>	414-771-1711; or Mary Pikus 414-778-5233 Fax 414-771-7640	<a href="http://www.dentalassociates.com">www.dentalassociates.com</a>  or <a href="mailto:mpikus@dentalassociates.com">mpikus@dentalassociates.com</a>
<b>Employee Assistance Program (EAP)</b>	800-236-3231	<a href="http://www.Aurora.org/eap">www.Aurora.org/eap</a>
<b>ETF (WRS Pension/Life Insurance)</b>	877-533-5020	<a href="http://www.etf.wi.gov">www.etf.wi.gov</a>
<b>Employee Benefits Corporation (EBC) - Section 125: Flexible Spending</b>	Fax Claims: 608-831-4790 Phone Support: 800-346-2126	<a href="http://www.ebcflex.com">www.ebcflex.com</a>
<b>Tri-City Bank Health Savings Account (HSA)</b>	888-574-2489	<a href="http://www.tcnb.com">www.tcnb.com</a>
<b>ICMA (Tyge Olson)</b>	866-328-4677 Fax 262-377-7299	<a href="mailto:tolson@icmarc.org">tolson@icmarc.org</a>
<b>MetLife (Keith Olson or Pete Voss)</b>	414-541-4490 Fax 414-541-4656	<a href="mailto:Kolson1@metlife.com">Kolson1@metlife.com</a> or <a href="mailto:Pvoss@metlife.com">Pvoss@metlife.com</a>
<b>WI Deferred Compensation (WDC) (Joe Herron)</b>	877-457-9327 Fax 608-241-6045	<a href="mailto:Joseph.herron@greatwest.com">Joseph.herron@greatwest.com</a> Website: <a href="http://www.wdc457.org">www.wdc457.org</a>

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## IMPORTANT MESSAGE REGARDING CHANGES IN YOUR STATUS

As always, it remains the employee's responsibility to notify Human Resources within 30 days of a qualifying event\* (e.g., marriage, divorce, legal separation, birth/adoption/legal placement, Medicare/Medicaid/Title 19 eligibility, attaining Medicare age, or dependent no longer qualifies for health and/or dental benefits) and/or to make a change to health/dental/life insurance coverage. When a change is communicated to Human Resources, such information is forwarded to our third party administrators and to Payroll for processing. The change may or may not affect your monthly insurance premium share deductions.

We continually strive for accuracy in reporting such changes but to some degree expect occasional oversights. The City has no formal process available to audit payroll deductions for health insurance. For this reason we encourage employees to be diligent in reviewing their payroll check stubs on a regular basis for accuracy. Errors reported timely can be corrected in an efficient manner.

\*Must provide proof of qualifying event where applicable (e.g., marriage/birth certificate, divorce decree)

## ARE YOUR PENSION AND LIFE INSURANCE BENEFICIARY DESIGNATIONS UP TO DATE?

Under current WRS law all death benefits must be paid according to the last beneficiary designation you filed with the Department of Employee Trust Funds (ETF), regardless of any changes in your personal situation. **It is extremely important you keep your designation up-to-date.** If you think your designation may be out of date, the easiest way to make sure your designation meets your current needs is to file a new designation. It will replace any old designation you have filed, and will provide ETF with current information about your beneficiaries; this helps ETF locate your beneficiaries upon your death. Download or print a beneficiary designation form from ETFs website, [etf.wi.gov](http://etf.wi.gov). You can also call them toll-free at 877-533-5020. Additionally, forms are available on the Intranet and from Human Resources, 414-302-8270.



# HEALTH INSURANCE

The City's health insurance will be administered by Anthem, 844-286-6371, [www.anthem.com](http://www.anthem.com).

This year the City is offering two (2) plan options: (1) PPO Plan with eligibility to participate in a medical reimbursement program through the Section 125 Flexible Spending Account (FSA) program, and (2) HDHP (High Deductible Health Plan) with eligibility to participate in a medical reimbursement program through a Health Savings Account (HSA).

Both plans provide a prescription drug program for retail and mail order through Express Scripts. You may continue to have your prescriptions filled at a local pharmacy or through Express Scripts mail order. Members will be required to obtain all new prescriptions for mail order and specialty pharmacy prescriptions.

- A. **You must enroll** in a health plan option listed above to have health insurance coverage in effect for plan year beginning March 1, 2016.
1. Complete the enclosed *Health and/or Standard Dental Application* form.
  2. Employees who maintain coverage for dependents (spouse and/or child[ren]) and/or who intend to add dependents (spouse and/or child[ren]) to their health insurance are required to determine coverage eligibility (refer to the dependent definition found within this booklet). Proper documentation (e.g., marriage/birth/adoption certificate) must be provided for qualified dependents being added to the plan who did not have coverage immediately prior to this enrollment period.
- B. Return your enrollment form to the Human Resources Department on or before **5:00 p.m., Wednesday, February 10, 2016; YOUR FORM MUST BE RECEIVED EVEN IF YOU CHOOSE TO DECLINE COVERAGE.** (If you are declining health coverage, you will need to complete a *Waiver of Coverage* form.) Information on the health plans, including the waiver of coverage, is available on the City's website at [www.westalliswi.gov/openenrollment](http://www.westalliswi.gov/openenrollment), or from Human Resources, City Hall, Monday - Friday, 8:00 a.m. - 5:00 p.m., 414-302-8270.

**NOTE: Domestic partners are not eligible for health insurance coverage.**

**Monthly premium share contributions for the Health Insurance Plan Offerings:**

Effective March 1, 2016, a regular full-time employee will be subject to contributing, on a pre-tax basis, 10% per month towards the monthly premium if they participated in the City-sponsored Health Risk Assessment (HRA) offered in Fall, 2015, OR 20% if they did not participate in the HRA.\* A regular part-time employee holding a minimum of 0.5 FTE (full-time equivalent) budgeted position continues to be prorated based on FTE; contact the Finance Department for your rate calculation.

<b>MONTHLY PREMIUMS AND PREMIUM SHARE EFFECTIVE 3-1-16*</b>						
Plan Type	PPO PLAN			HDHP (High Deductible Health Plan)		
	Monthly Premium	Employee Share		Monthly Premium	Employee Share	
10% w/HRA		20% w/out HRA	10% w/HRA		20% w/out HRA	
Emple Only	\$ 591	\$ 59.10	\$118.20	\$ 761	\$ 76.10	\$152.20
Emple plus 1	\$1158	\$115.80	\$231.60	\$1491	\$149.10	\$298.20
Emple plus 2+	\$1696	\$169.60	\$339.20	\$2183	\$218.30	\$436.60

\*Police and Fire Union members' monthly premium share contributions pending contract negotiations.



# PPO PLAN

## In-Network or Out-of-Network Providers

In-Network: when seeking care *in* the *Blue Priority* service area (refer to map), select “*Blue Priority*” network to verify provider participation (NOTE: when seeking care outside of the Blue Priority service area in Wisconsin, services will be subject to the out-of-network benefit levels); when seeking care *outside of* Wisconsin, select “*National PPO (BlueCard PPO)*” to verify provider participation;

Out-of-Network: any non- “*Blue Priority*” or “*National PPO (BlueCard PPO)*” provider.

## Pharmacy Provider

In-Network: eligible prescriptions processed through “*Express Scripts (ESI)*” retail and mail order pharmacy network;

Out-of-Network: any non- “*Express Scripts (ESI)*” retail or mail-order pharmacy.





## PPO PLAN BENEFIT SUMMARY - ACTIVE EMPLOYEES

This document is meant as a summary description of basic benefit coverage. It cannot add to or take away from any legal plan. This document describes the benefit program in general terms. It is not intended to be a complete description of coverage.

**THE CITY'S HEALTH INSURANCE PLAN HAS THE FOLLOWING EXCLUSIONS:** Dental care, cosmetic surgery unless medically necessary, eyeglasses, contact lenses, dentures, hearing aids for adults, custodial or domiciliary care, experimental medical procedures, examinations for employment, sports or purchase of insurance, care required while in government operated facility or services required while incarcerated or in military service. Refer to your Benefit Booklet for further details.

	<b>IN NETWORK SERVICES</b>	<b>OUT OF NETWORK SERVICES</b>
	<p>ANTHEM <i>Blue Priority</i> provider network for services <u>within</u> Wisconsin Service Area.</p> <p>ANTHEM <i>National PPO (BlueCard PPO)</i> for services <u>outside of</u> Wisconsin.</p>	
<b>MAXIMUM COVERAGE</b>	No dollar limit. <i>Payment of services will depend on how providers bill.</i>	No dollar limit. <i>Payment of services will depend on how providers bill.</i>
<b>DEDUCTIBLE</b>	Unless otherwise noted, deductibles of \$100 per person or \$300 per family per Plan year for medical services (excludes Routine Preventative Services and Copays).	Unless otherwise noted, deductibles of \$15,000 per person or \$30,000 per couple/family per Plan year for combined medical and prescription drug services.
<b>COINSURANCE (PERCENT OF COVERED CHARGES)</b>	100% of eligible charges after applicable deductible/copays have been satisfied.	Unless otherwise noted, the Plan pays 80% of eligible charges after the deductible has been satisfied.
<b>ANNUAL OUT-OF-POCKET (LIMIT ON EXPENSES)</b>	Maximum out-of-pocket coinsurance, including all applicable copays (excluding prescription drug copays) is \$4,850 per person or \$9,700 per couple/family per Plan year.	Maximum out-of-pocket coinsurance (including the deductible) is \$30,000 per person or \$60,000 per couple/family per Plan year; thereafter, the Plan pays 100% of eligible charges.
<b>PHYSICIAN OFFICE VISITS</b>	<p><b>\$20</b> Primary Care Physician office visit co-pay (Family Practice, General Practitioner, Pediatrician, Internal Medicine, OB/GYN, GYN, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, and Clinical/Multi-specialty Group).</p> <p><b>\$40</b> Specialist visit copay (qualified practitioners not listed above).</p> <p><b>Note:</b> Co-pays are waived for Routine Preventative Services.</p>	80% of eligible charges after deductible.
<b>EMERGENCY CARE</b>	Subject to a \$150 copay per emergency, then 100% of eligible charges after deductible. Copay waived if admitted inpatient or transported by ER vehicle.	Emergency services paid same as in network services. Non-emergency services paid at 80% after deductible.
<b>URGENT CARE FACILITY</b>	100% of eligible charges after deductible if billed as "urgent care" visit. Member subject to applicable copay (i.e., \$20 or \$40 Specialist copay if billed as "office visit"; \$150 copay if billed as "emergency visit").	80% of eligible charges after deductible.
<b>AMBULANCE</b>	100% of eligible charges after deductible when medically necessary.	80% of eligible charges after deductible.
<b>HOSPITALIZATION</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>SURGICAL CARE OR SURGERY</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>PHYSICIAN VISITS IN HOSPITAL</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.

PPO Plan Benefit Summary - Active Employees

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
<b>ROUTINE PREVENTATIVE CARE:</b> Women's Health Services; Routine Adult Physicals; Well Child Care; Immunizations (Child & Adult); Flu Shots; Diagnostic X-Rays and Lab Tests; Colon Cancer Screening; Prostate Cancer Screening; Pap Smear; Mammography; Vision Exam; Hearing Exam	100% of eligible charges; deductible/copay is waived.	Not covered.
<b>INJECTIONS</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>ALLERGY CARE</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>DIAGNOSTIC X-RAY, LAB SERVICES (Non-Routine)</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>PODIATRY SERVICES (Non-Routine)</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>HEARING EXAM (Non-Routine)</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>EYE EXAM (Non-Routine)</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>MATERNITY</b>	Hospital & physician charges covered at 100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>PEDIATRIC CARE (Non-Routine)</b>	100% of eligible charges. Subject to applicable copay.	80% of eligible charges after deductible.
<b>HEALTH EDUCATION &amp; COUNSELING (Non-Routine)</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>ORAL SURGERY</b>	100% of eligible charges after deductible for initial treatment for injury to sound, natural teeth and for specific diseases, including removal of partially or completely unerupted impacted teeth.	80% of eligible charges after deductible for initial treatment for injury to sound, natural teeth and for specific diseases, including removal of partially or completely unerupted impacted teeth.
<b>THERAPIES – CARDIAC, CHEMO, DIALYSIS/ HEMODIALYSIS, INFUSION RADIATION, AND RESPIRAORY (Inpatient/Outpatient)</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.
<b>CHIROPRACTIC CARE</b>	100% of eligible, medically necessary charges after deductible. <i>Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.</i>	80% of eligible, medically necessary charges after deductible.
<b>PHYSICAL THERAPY</b>	100% of eligible, medically necessary charges after deductible. <b>NOTE:</b> Subject to applicable copay if provider bills as an office visit; if billed as a physical therapy appointment, copay will not apply. <i>Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.</i>	80% of eligible, medically necessary charges after deductible.
<b>OCCUPATIONAL THERAPY</b>	100% of eligible, medically necessary charges after deductible. <i>Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.</i>	80% of eligible, medically necessary charges after deductible.

PPO Plan Benefit Summary - Active Employees

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES															
<b>MENTAL HEALTH &amp; ALCOHOL/ SUBSTANCE ABUSE:</b>  <b>Inpatient, Residential</b>  <b>Outpatient Therapy and Office Visit Services</b>  <b>Partial Hospitalization</b>	100% of eligible charges after deductible.  100% of eligible charges; deductible is waived. Subject to applicable copay.  100% of eligible charges after deductible.	80% of eligible charges after deductible.															
<b>NOTE:</b> The City offers an Employee Assistance Program (EAP), administered by Aurora, in addition to the coverage provided under this insurance program; it is a separate and FREE benefit. For further information, contact the Aurora Employee Assistance Program at (800) 236-3231 OR the City's Human Resources Department at (414) 302-8270.																	
<b>DURABLE MEDICAL EQUIPMENT</b>	100% of eligible charges after deductible for initial purchase or rental when authorized; does not cover repair or replacement.	80% of eligible charges after deductible for initial purchase or rental when authorized; does not cover repair or replacement.															
<b>DEPENDENT COVERAGE</b>	Refer to the last page of this document for details.																
<b>COORDINATION OF BENEFITS</b>	Benefits under this Plan are coordinated with benefits provided by other plans for which you and/or your dependents are also covered. Refer to the <i>Coordination of Benefits</i> section in your Benefit Booklet for details.																
<b>PRE-CERTIFICATION</b>	Required for non-emergency Inpatient Hospital Admissions (includes Mental Health, Alcohol/Substance Abuse), Surgical Procedures, Outpatient Care, Skilled Nursing Facility, Home Health Care, and Hospice Care.																
<b>PRESCRIPTION DRUGS</b>	IN NETWORK SERVICES	OUT OF NETWORK SERVICES															
	<b>Retail: Express Scripts, Inc.</b> <b>Mail Order: Express Scripts, Inc.</b>																
	Cost per prescription or refill; up to 34-day retail supply and 90-day mail order supply (includes insulin & diabetic supplies).  Prescriptions are not subject to the annual deductible.	80% of charges per prescription or refill up to a 34-day supply after deductible.															
	<table border="1"> <thead> <tr> <th></th> <th>Retail</th> <th>Mail Order</th> </tr> </thead> <tbody> <tr> <td>Low cost generic and brand name drugs on Plan Manager's Drug List</td> <td>\$15</td> <td>\$37.50</td> </tr> <tr> <td>High cost generic and brand name drugs on Plan Manager's Drug List</td> <td>\$25</td> <td>\$62.50</td> </tr> <tr> <td>Generic and brand name drugs not on Plan Manager's Drug List</td> <td>\$35</td> <td>\$87.50</td> </tr> <tr> <td>Specialty Medications</td> <td colspan="2">5% copay with maximum of \$100 per script per month.</td> </tr> </tbody> </table>		Retail	Mail Order	Low cost generic and brand name drugs on Plan Manager's Drug List	\$15	\$37.50	High cost generic and brand name drugs on Plan Manager's Drug List	\$25	\$62.50	Generic and brand name drugs not on Plan Manager's Drug List	\$35	\$87.50	Specialty Medications	5% copay with maximum of \$100 per script per month.		
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Generic and brand name drugs not on Plan Manager's Drug List	\$35	\$87.50															
Specialty Medications	5% copay with maximum of \$100 per script per month.																
	<b>Maximum out of pocket for all prescription tiers combined is \$1,500 per person or \$3,000 per couple/family per Plan year.</b>  <b>Note: Prescriptions for equipment/items deemed medically necessary (such as, but not limited to, crutches, compression stockings, nebulizers, diabetic meters, etc.) are covered under the <i>Durable Medical Equipment</i> section and track toward the annual medical out-of-pocket limit on expenses.</b>																

The City reserves the right to make changes to coverage if future non-discrimination testing rules or plan structure makes it impossible to provide coverage.

## PPO Plan Benefit Summary - Active Employees

**Dependent** means a covered **employee's**:

1. Legally recognized spouse;
2. Natural blood related child, step-child, legally adopted child or a child under **your** legal guardianship as determined with a court decree whose age is less than the limiting age. Each child must legally qualify as a **dependent** as defined by the United States Internal Revenue Service guidelines or applicable State Statutes.

**Limiting age and eligibility criteria:**

**Dependent children under age 26 (as required by federal and state mandates):**

The limiting age for each **dependent** child is the end of the month he or she attains the age of 26 years, regardless if the child is:

- a. Married;
- b. A tax dependent;
- c. A student;
- d. Employed;
- e. Residing with or receives financial support from *you*; or
- f. Eligible for other coverage through employment.

**Dependent child, age 26 and older (as required by State mandate), who is called to federal active duty:**

The limiting age is any age for each **dependent** child age 26 and older when they meet the requirements outlined below. **Dependent** termination is the end of the month they no longer meet these requirements.

- The child is a full-time student; and
  - The child was 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 an institution of higher education on a full-time basis; and
  - The child was under age 27 when called to federal active duty; and
  - The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; and
  - If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.
3. A covered **employee's** child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
  4. Grandchild, as long as the **employee's** covered **dependent**, who is the parent of the grandchild, is not yet age 18.

**You** must furnish satisfactory proof to the **City** upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

A covered **dependent** child who attains the limiting age while covered under the Plan will remain eligible for medical benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a **dependent** as determined by the United States Internal Revenue Service;
4. Unmarried.

**You** must furnish satisfactory proof to the **City** that the above conditions continuously exist on and after the date the limiting age is reached. The **City** may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

# Finding In-network Providers in the *Blue Priority* Network

[www.Anthem.com](http://www.Anthem.com)

The *Blue Priority* network is for individuals whose primary residence is located within Anthem's *Blue Priority* service area (refer to map):

- ✓ select “**Blue Priority**” when seeking care

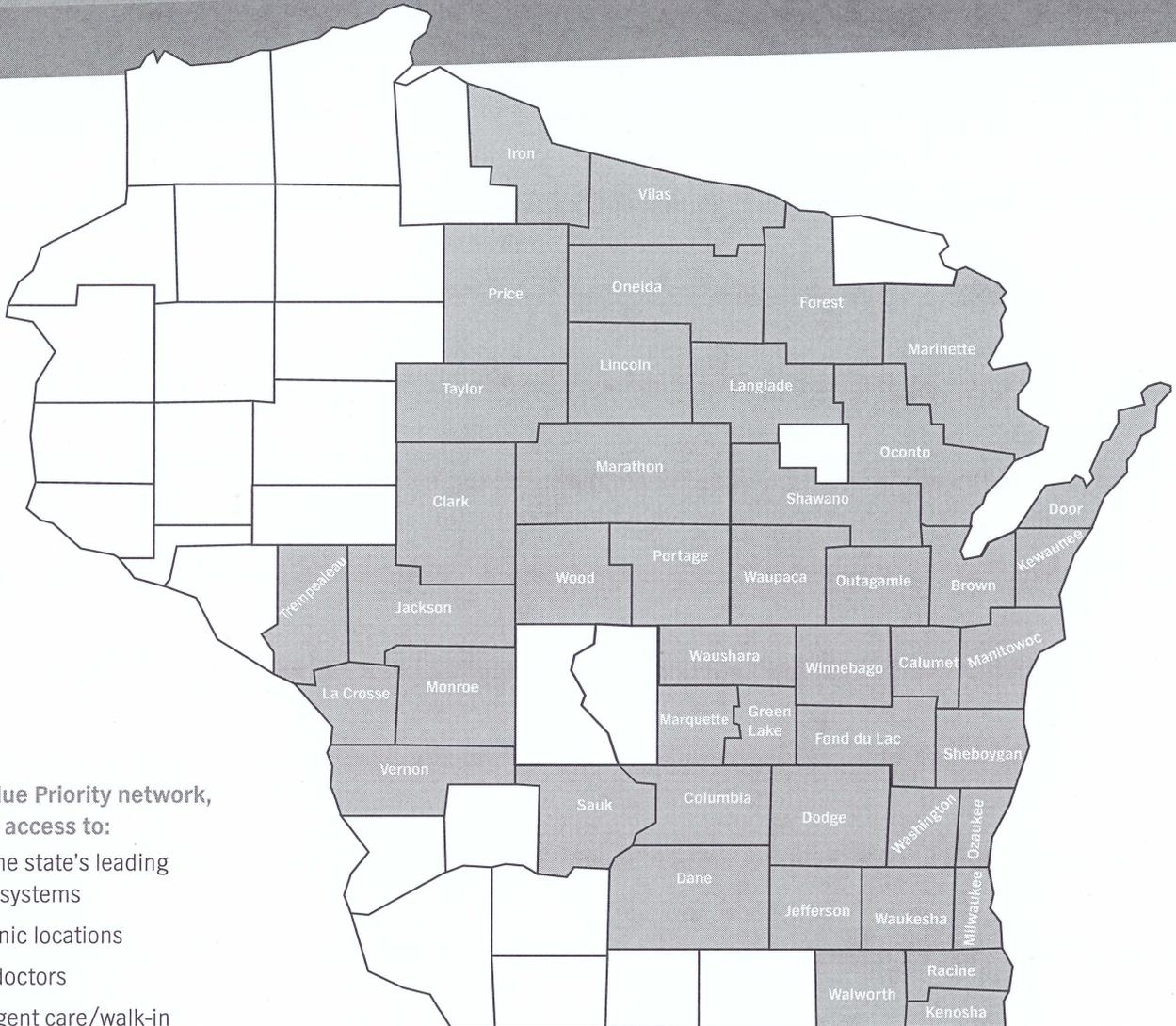
To begin your search, log into [www.anthem.com](http://www.anthem.com)

1. Select “Find A Doctor” on the right-hand side of the screen.
2. Under “Search as a Guest” select “Search by Selecting a Plan or Network” (DO NOT choose “CONTINUE”).
3. For “What type of care are you searching for?” choose Medical.
4. For “What state do you want to search in?” choose whichever state you will be receiving services.
5. For “Select a plan/network” choose the *Blue Priority* network under the “Medical Networks”; choose the *National PPO (BlueCard PPO)* network under the “Employer-Sponsored Networks” option for services in any state other than Wisconsin.
6. Select “Continue”.
7. The next screen will allow you to select the following:
  - a. Type of Provider
  - b. Enter Name of Provider (not required)
  - c. Demographic Information (City and State).
8. Click “Search”. A list with the selected type of providers in your demographic area will appear.

**Questions? Contact Anthem at 844-286-6371**

# Blue Priority service area

## Small and Large Group



### With the Blue Priority network, you'll have access to:

- 12 of the state's leading health systems
- 844 clinic locations
- 5,500 doctors
- 85+ urgent care/walk-in clinic locations
- 34 hospitals
  - Children's Hospital of Wisconsin and American Family Children's Hospital
  - 10+ cancer treatment centers
- Services in 45 counties and 130 communities
- When traveling outside the state, access to more than 90% of U.S. hospitals and 80% of doctors through the BlueCard® program\*

\* The BlueCard program: Blue Cross and Blue Shield Association, [bcbs.com/about](http://bcbs.com/about).

#### **Brown**

Aurora Health Care  
Bellin  
ThedaCare

#### **Calumet**

Aurora Health Care  
Bellin  
ThedaCare

#### **Clark**

Aspirus  
University of Wisconsin Hospitals and Clinics

#### **Columbia**

University of Wisconsin Hospitals and Clinics

#### **Dane**

University of Wisconsin Hospitals and Clinics  
American Family Children's Hospital  
Meriter

#### **Dodge**

Aurora Health Care  
Watertown  
University of Wisconsin Hospitals and Clinics  
Meriter

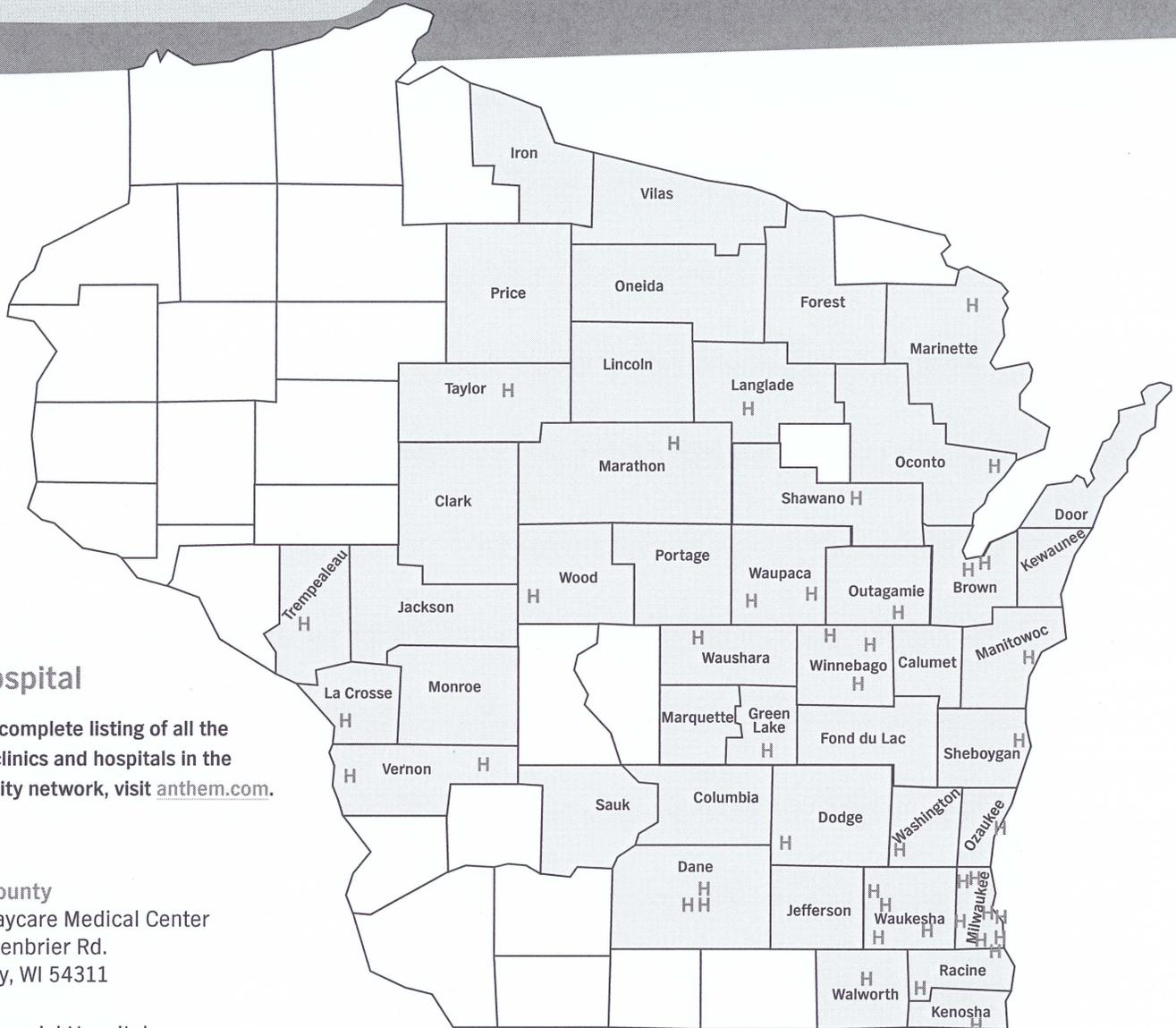
#### **Door**

Aurora Health Care  
Bellin

<b>Fond du Lac</b> Aurora Health Care ThedaCare University of Wisconsin Hospitals and Clinics Community Health	<b>Langlade</b> Aspirus	<b>Outagamie</b> Aurora Health Care Bellin University of Wisconsin Hospitals and Clinics	<b>Vilas</b> Aspirus
<b>Forest</b> Aurora Health Care	<b>Lincoln</b> Aspirus	<b>Ozaukee</b> Aurora Health Care	<b>Walworth</b> Aurora Health Care
<b>Green Lake</b> Community Health Network	<b>Manitowoc</b> Aurora Health Care Bellin	<b>Portage</b> Aspirus	<b>Washington</b> Aurora Health Care
<b>Iron</b> Aspirus	<b>Marathon</b> Aspirus University of Wisconsin Hospitals and Clinics	<b>Price</b> Aspirus	<b>Waukesha</b> Aurora Health Care Children's Hospital of Wisconsin ProHealth Care
<b>Jackson</b> Gundersen	<b>Marinette</b> Bellin Bay Area Medical Center	<b>Racine</b> Aurora Health Care	<b>Waupaca</b> Aurora Health Care ThedaCare
<b>Jefferson</b> Aurora Health Care University of Wisconsin Hospitals and Clinics ProHealth Care	<b>Marquette</b> Community Health Network	<b>Sauk</b> University of Wisconsin Hospitals and Clinics	<b>Waushara</b> Aurora Health Care Community Health Wild Rose ThedaCare
<b>Kenosha</b> Aurora Health Care University of Wisconsin Hospitals and Clinics	<b>Milwaukee</b> Aurora Health Care Children's Hospital of Wisconsin	<b>Shawano</b> Aurora Health Care Bellin ThedaCare Aspirus	<b>Winnebago</b> Aurora Health Care ThedaCare Children's Hospital of Wisconsin Bellin University of Wisconsin Hospitals and Clinics
<b>Kewaunee</b> Aurora Health Care Bellin	<b>Monroe</b> Gundersen	<b>Sheboygan</b> Aurora Health Care	
<b>LaCrosse</b> Gundersen University of Wisconsin Hospitals and Clinics	<b>Oconto</b> Aurora Health Care Bellin	<b>Taylor</b> Aspirus	
	<b>Oneida</b> Aspirus University of Wisconsin Hospitals and Clinics	<b>Trempleau</b> Gundersen	<b>Wood</b> Aspirus University of Wisconsin Hospitals and Clinics
		<b>Vernon</b> Gundersen	

To view a complete listing of all the doctors, clinics and hospitals in the Blue Priority network, visit [anthem.com](http://anthem.com).

# Hospitals within the Blue Priority Service Area



## H = Hospital

To view a complete listing of all the doctors, clinics and hospitals in the Blue Priority network, visit [anthem.com](http://anthem.com).

**Brown County**  
Aurora Baycare Medical Center  
2845 Greenbrier Rd.  
Green Bay, WI 54311

**Bellin Memorial Hospital**  
744 S. Webster Ave.  
Green Bay, WI 54301

**Dane County**  
American Family Children's Hospital  
1675 Highland Ave.  
Madison, WI 53792

**Meriter Hospital Inc.**  
202 S. Park St.  
Madison, WI 53715

**University of Wisconsin Hospital**  
600 Highland Ave.  
Madison, WI 53792

**Dodge County**  
Watertown Regional Medical Center  
125 Hospital Dr.  
Watertown, WI 53098

**Green Lake County**  
Berlin Memorial Hospital  
225 Memorial Drive  
Berlin, WI 54923

**Kenosha County**  
Aurora Medical Center Kenosha  
10400 75th St.  
Kenosha, WI 53142

**La Crosse County**  
Gundersen Lutheran Medical Center  
1910 South Ave.  
La Crosse, WI 54601

**Langlade County**  
Langlade Hospital  
112 E. 5th Ave.  
Antigo, WI 54409

**Manitowoc County**  
Aurora Medical Center Manitowoc  
5000 Memorial Dr.  
Two Rivers, WI 54241

**Marathon County**

Aspirus Wausau Hospital  
333 Pine Ridge Blvd.  
Wausau, WI 54401

**Marinette County**

Bay Area Medical Center  
3100 Shore Dr.  
Marinette, WI 54143

**Milwaukee County**

Aurora Psychiatric Hospital  
1220 Dewey Ave.  
Wauwatosa, WI 53213

Aurora Sinai Medical Center  
945 N. 12th St.  
Milwaukee, WI 53233

Aurora St. Luke's Medical Center  
2900 W. Oklahoma Ave.  
Milwaukee, WI 53215

Aurora St. Luke's South Shore  
5900 S. Lake Dr.  
Cudahy, WI 53110

Aurora West Allis Medical Center  
8901 W. Lincoln Ave.  
West Allis, WI 53227

Aurora Women's Pavilion of Aurora West  
Allis Medical Center  
8901 W. Lincoln Ave.  
West Allis, WI 53227

Children's Hospital of Wisconsin  
9000 W. Wisconsin Ave.  
Milwaukee, WI 53226

Select Specialty Hospital —  
Milwaukee Inc.  
8901 W. Lincoln Ave.  
West Allis, WI 53227

**Oconto County**

Bellin Health Oconto Hospital  
820 Arbutus Ave.  
Oconto, WI 54153

**Outagamie County**

Appleton Medical Center  
1818 N. Meade St.  
Appleton, WI 54911

**Ozaukee County**

Aurora Medical Center Grafton  
975 Port Washington Rd.  
Grafton, WI 53024

**Racine County**

Aurora Memorial Hospital  
of Burlington  
252 McHenry St.  
Burlington, WI 53105

**Shawano County**

Shawano Medical Center  
309 N. Bartlett St.  
Shawano, WI 54166

**Sheboygan County**

Aurora Sheboygan Memorial  
Medical Center  
2629 N. 7th St.  
Sheboygan, WI 53083

**Taylor County**

Aspirus Medford Hospital  
135 S. Gibson St.  
Medford, WI 54451

**Trempealeau County**

Tri-County Memorial Hospital  
18601 Lincoln Ave.  
Whitehall, WI 54773

**Vernon County**

St. Joseph's Health Services Inc.  
400 Water Ave.  
Hillsboro, WI 54634

Vernon Memorial Hospital  
507 S. Main St.  
Viroqua, WI 54665

**Walworth County**

Aurora Lakeland Medical Center  
W3985 County Rd. NN  
Elkhorn, WI 53121

**Washington County**

Aurora Medical Center Hartford  
1032 E. Sumner St.  
Hartford, WI 53027

**Waukesha County**

Aurora Medical Center Summit  
36500 Aurora Dr.  
Summit, WI 53066

Oconomowoc Memorial Hospital  
791 Summit Avenue  
Oconomowoc, WI 53066

Rehabilitation Hospital of Wisconsin  
1625 Coldwater Creek Drive  
Waukesha, WI 53188

Waukesha Memorial Hospital  
725 American Ave.  
Waukesha, WI 53188

**Waupaca County**

Riverside Medical Center  
800 Riverside Dr.  
Waupaca, WI 54981

ThedaCare Medical Center —  
New London  
1405 Mill St.  
New London, WI 54961

**Waushara County**

Wild Rose Community  
Memorial Hospital  
601 Grove Ave.  
Wild Rose, WI 54984

**Winnebago County**

Aurora Medical Center Oshkosh  
855 N. Westhaven Dr.  
Oshkosh, WI 54904

Children's Hospital of  
Wisconsin Fox Valley  
130 2nd St.  
Neenah, WI 54956

Theda Clark Regional Medical Center  
130 2nd St.  
Neenah, WI 54956

**Wood**

Riverview Hospital  
410 Dewey St.  
Wisconsin Rapids, WI 54494

To view a complete listing of all the  
doctors, clinics and hospitals in the  
Blue Priority network, visit [anthem.com](http://anthem.com).

# Finding In-network Providers in the *National PPO (BlueCard PPO) Network* [www.Anthem.com](http://www.Anthem.com)

The *National PPO (BlueCard PPO)* network is for those whose primary residence is in Wisconsin but seeking care outside of Wisconsin.

- ✓ Select “***National PPO (Bluecard PPO)***” when seeking care

To begin your search, go to [www.anthem.com](http://www.anthem.com)

1. Select “Find A Doctor” on the right-hand side of the screen.
2. Under “Search as a Guest” select “Search by Selecting a Plan or Network” (DO NOT choose “CONTINUE”).
3. For “What type of care are you searching for?” choose Medical.
4. For “What state do you want to search in?” choose the state in which you are seeking care.
5. For “Select a plan/network” choose “*National PPO (BlueCard PPO)*” under the “Medical Networks” option for services in Wisconsin or “Medical Employer-Sponsored” option for services in any state other than Wisconsin.
6. Select “Continue”.
7. The next screen will allow you to select the following:
  - a. Type of Provider
  - b. Enter Name of Provider (not required)
  - c. Demographic Information (City and State).
8. Once you continue, you will be provided with the selected type of providers in your demographic area provided.

**Questions? Contact Anthem at 844-286-6371**

## PPO PLAN MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

In December of 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act. One of the benefits of this law is to give all Medicare eligible individuals the right, and the availability, to participate in a government sponsored prescription drug plan. The prescription drug plan is known as **Medicare Part D**. The effective date for Medicare Part D was January 1, 2006.

One of the requirements of this legislation is that an employer must inform its Medicare eligible employees whether the prescription drug coverage they have available under the employer's health plan or prescription drug plan, is creditable coverage or non-creditable coverage. This requirement is met by an employer providing a specific Notice of Creditable Coverage or Notice of Non-Creditable Coverage.

- **Creditable coverage** is prescription drug coverage which is expected to pay out at least as much, or greater than, the Medicare Part D prescription drug plan will pay.
- **Non-creditable coverage** is prescription drug coverage which is NOT expected to pay out as much as the Medicare Part D prescription drug plan will pay.

The **difference** between creditable coverage and non-creditable coverage is **very important to you**. If you are currently covered under a prescription drug plan which has non-creditable coverage and are **eligible to enroll in Medicare Part D but choose not to do so**, you may be charged at minimum, a **1% premium surcharge** for every month you were eligible to enroll in Part D, but did not enroll. **However, if you can show that you were covered by a prescription drug plan that had creditable coverage, then this premium surcharge will be waived** at the time of enrollment in Medicare Part D.

Therefore, this is to inform you that as a participant in the City of West Allis PPO health insurance Plan it has been determined that you have **creditable prescription drug coverage**. This information is not only important to you, but to your spouse and/or dependents covered under the City's plan(s) who may be Medicare eligible.

Following is the City's Notice of Creditable Coverage. **This is a very important document and should be kept in a secure place.** It contains more information about your creditable coverage and Medicare Part D.

For more information on the Medicare Part D program and/or your eligibility for coverage, visit [www.medicare.gov](http://www.medicare.gov) for personalized help or call 800-MEDICARE, 800-633-4227. TTY users should call 877-486-2048.

If you have any questions regarding this communication please do not hesitate to contact Jane Barwick, Principal Human Resources Analyst, at 414-302-8272 (M-F, 7:30 AM – 4:00 PM) or Audrey Key, Human Resources Director, at 414-302-8274 (M-F, 8:30 AM – 5:00 PM).

# PPO PLAN IMPORTANT NOTICE ABOUT YOUR 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 the City of West Allis 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. The City of West Allis has determined that the prescription drug coverage offered by the City of West Allis PPO Plan 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.

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## 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 15<sup>th</sup> through December 7<sup>th</sup>**. 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?

If you decide to join a Medicare drug plan, your current coverage with the City of West Allis will be affected. If you do decide to join a Medicare drug plan and drop your current City of West Allis PPO Plan coverage, be aware that you may not be able to get this coverage back later. **Your current coverage also pays for other health expenses, in addition to prescription drugs. Therefore, you will not be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in the Medicare prescription drug 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 the City of West Allis PPO Plan 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 November to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact Jane Barwick, Principal Human Resources Analyst, at 414-302-8272 (M-F, 7:30 AM – 4:00 PM) or Audrey Key, Human Resources Director, at 414-302-8274 (M-F, 8:30 AM – 5:00 PM)

**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 the City of West Allis 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.

- Visit [www.medicare.gov](http://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 800-MEDICARE, 800-633-4227. TTY users should call 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](http://www.socialsecurity.gov), or call them at 800-772-1213; TTY 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 whether or not you are required to pay a higher premium (a penalty).**

Date: January 25, 2016

Name of Entity/Sender: City of West Allis/Human Resources Department

Contact--Position/Office: Jane Barwick (Principal Human Resources Analyst) or Audrey Key  
(Human Resources Director)

Address: 7525 W. Greenfield Avenue, West Allis, WI 53214

Main Office Phone Number for the City's Human Resources Department: 414-302-8270

This notice will be distributed annually with the insurance open enrollment information; copies may be requested at any time.

## **SECTION 125 FLEXIBLE SPENDING: MEDICAL REIMBURSEMENT**

A Section 125 Flexible Spending Account (FSA) for Medical Reimbursement allows an employee to have dollars deducted from their paycheck on a pre-tax basis to pay for certain planned medical, dental and vision expenses (such as deductibles/ copays/prescription drugs/eyeglasses/contacts/medical equipment and supplies, etc.) not covered by insurance. The program is administered by Employee Benefits Corporation (EBC), 800-346-2126; [www.ebcflex.com](http://www.ebcflex.com) or [www.participantservices@ebcflex.com](mailto:www.participantservices@ebcflex.com).

1. Employees wishing to enroll or re-enroll in the Medical Reimbursement program MUST complete a new enrollment form and return to the Finance Department **NO LATER THAN 5:00 p.m. Wednesday, February 10, 2016.**
2. No action is necessary if you wish to discontinue your current allotments for medical reimbursement.
3. You may participate in the plan even if you are not enrolled in the City's health or dental insurance plans.
4. This plan option is not available to employees who elect participation in a High Deductible Health Plan (HDHP).
5. The plan year runs from March 1, 2016 through February 28, 2017, with an additional 2-1/2 month grace period to spend and submit claims (through May 15, 2017). Any eligible health, dental or vision expenses you incur during the grace period, between March 1, 2017 through May 15, 2017, would be eligible to be reimbursed from your 2016 account as well as from your 2017 account, *if* you re-enroll in the program in 2017. In other words, the grace period provides "overlapping coverage." Funds that are not used in a timely manner are forfeited.

Per federal health care reform (HCR) the Section 125 Medical Reimbursement annual limit for 2016 is \$2550.

### **\*IMPORTANT\***

**Employee Benefits Corporation strongly recommends employees have their medical reimbursements deposited directly into a personal savings or checking account; this can be accomplished by completing EBC's *Authorization for Direct Deposit* form included in your Open Enrollment packet. If you do not choose this option, it is your responsibility to notify EBC in the event you have a change in address; failure to do so may result in a \$25 forfeiture for each returned check.**

## **HOW DOES A FLEXIBLE SPENDING ACCOUNT (FSA) FOR MEDICAL REIMBURSEMENT WORK?**

An employee decides on a dollar amount (\$300 minimum contribution; \$2,550 maximum) they want to contribute to a Medical FSA based on estimated out-of-pocket expenses for the upcoming Plan year. (Note: High Deductible Health Plan participants are ineligible to participate.) The election amount (which is divided over 26 pay periods in the Plan year) is deducted pretax from each paycheck and held in a Medical FSA. After the employee and/or eligible spouse/dependent(s) incur(s) an eligible expense, a claim is submitted by the employee to the City's Section 125 third party administrator for processing; claims may be submitted via smartphone, fax, US Mail, or online. The employee will be sent a reimbursement check for the incurred expenses. The check is paid from the employee's Medical FSA. **FUNDS NOT USED WITHIN THE PLAN YEAR ARE FORFEITED.**

## **WHAT ARE THE ADVANTAGES OF A FSA FOR MEDICAL REIMBURSEMENT?**

An FSA for Medical Reimbursement allows you to increase your take-home pay by reducing your taxable income. Wages used in your medical FSA are not subject to federal, state or social security tax. As a direct result of the personal tax savings, you will actually increase your spendable income by changing the payment of your expenses from an after-tax to a pre-tax basis. Generally this could mean a potential tax savings of up to 30% on expenses you are already paying for. (Actual tax savings depends on your tax bracket.)

## **CAN I CHANGE MY ELECTION AT ANY TIME?**

No; your election amount will remain in effect for the plan year. Changes in elections may only be made if you experience a qualified change in status. The IRS defines a qualified change in status to include:

- Change in your legal marital status
- Change in the number of your tax dependents
- Your dependent satisfies (or ceases to satisfy) eligibility requirements such as reaching the age limit or getting married
- Change in residence for you or your spouse or dependent that affects eligibility of your benefits
- Change in employment for you or your spouse or dependent that affects eligibility of your benefits

Questions or concerns regarding Section 125: Flexible Benefits may be directed to Employee Benefits Corporation (EBC), 800-346-2126, [www.ebcflex.com](http://www.ebcflex.com), or [www.participantservices@ebcflex.com](mailto:www.participantservices@ebcflex.com), or the City's Finance Department at 414-302-8260.



### Eligible Health Care FSA Expense Examples:

#### ■ Dental Services

Crowns/Bridges  
Dental X-Rays  
Dentures  
Exams/Teeth Cleanings  
Extractions  
Fillings  
Gum Treatments  
Oral Surgery  
Orthodontia/Braces

#### ■ Insurance-Related Items

Copays  
Coinsurance  
Deductibles

#### ■ Lab Exams/Tests

Blood Tests  
Cardiographs  
Diagnostic Fees  
Laboratory Fees  
Spinal Fluid Tests  
Urine/Stool Analyses  
X-Rays

#### ■ Medication

Insulin  
Prescribed Birth Control  
Prescribed Vitamins\*  
Prescription Drugs\*

#### ■ Other Medical Treatments/Procedures

Acupuncture  
Alcoholism (*inpatient treatment*)  
Chiropractor Services  
Drug Addiction (*inpatient treatment*)  
Hearing Exams  
Hospital Services  
Infertility  
In-vitro Fertilization  
Norplant Insertion or Removal  
Patterning Exercises  
Physical Examination (*not employment related*)  
Physical Therapy  
Speech Therapy  
Sterilization  
Vaccinations and Immunizations  
Vasectomy and Vasectomy Reversals  
Well Baby Care

#### ■ Other Medical Supplies and Services

Abdominal/Back Supports  
Ambulance Services

Arch Supports/Orthotic Insoles  
Breast Pumps and Lactation Supplies  
Contact Lens Solution and Cleaners  
Contraceptives  
Counseling (*except for Marriage and Family*)  
Crutches  
Guide Dog (*for visually/hearing impaired person*)  
Hearing Aids & Batteries  
Hospital Bed  
Insulin Supplies  
Learning Disability (*special school/teacher*)  
Lead Paint Removal (*if not capital expense and incurred for a child poisoned*)  
Mastectomy Bras  
Medic Alert Bracelet or Necklace  
Medical Miles, Tolls, and Parking  
Orthopedic Shoes\*\*  
Oxygen Equipment  
Pregnancy Tests  
Pre-natal Vitamins  
Prosthesis  
Rubbing Alcohol  
Splints/Casts  
Suntan Lotion/Sunscreen greater than SPF 14  
Syringes

Transportation Expenses (*essential to medical care*)

Wheelchair

Wigs (*hair loss due to disease*)

■ **Vision Expenses**

Contact Lenses

Contact Lens Solution

Eye Examinations

Eyeglasses

Laser Eye Surgeries

Prescription Sunglasses

Radial Keratotomy/LASIK

Reading Glasses

*This list is not meant to be all inclusive.*

*Other expenses not listed may also qualify.*

*Please refer to Section 213 of the Internal Revenue Code or call our toll-free Participant Services line at 800 346 2126.*

## Eligible with Doctor's Prescription:

**Important note about over-the-counter (OTC) drug reimbursement:** Due to health care reform regulations, the Health Care FSA only reimburses OTC drug expenses if you have and provide a doctor's prescription for them. Doctor's prescriptions must include the patient name, medication name, dosage, time frame for treatment and any other state law requirements. Make sure you plan your annual election accordingly.

Allergy Medicines

Antihistamines

Analgesics

Antacids

Anti-Diarrhea Medications

Anti-Itch Medications

Anti-Nausea Medications

Aspirin

Athletes Foot Creams and Powders

Cold Sore Remedies

Cough Drops

Cough Syrups

Decongestants

Eye Drops

Fever Reducers

First Aid Cream (*Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatments*)

Digestive Tract Relief Medications

Flu and Cold Medications

Hemorrhoidal Medications

Laxatives

Lice and Scabies Treatments

Menstrual Cycle Products (*medication for pain and cramp relief*)

Motion Sickness Pills

Muscle/Joint Pain Relievers

Nasal Sinus Sprays

Nicotine Gum/Patches

Pain Relievers

Pedialyte

Retin A (*non-cosmetic*)

Sinus Medications

Sleeping Aids

Smoking Cessation Products

Sore Throat Sprays

Special Ointments/Burn Ointments

Throat Lozenges

Vapor Rubs

Weight Loss Drugs (*to treat specific disease*)\*

Yeast Infection Treatments

## Ineligible Health Care FSA Expense Examples:

Baby-Sitting

Canceled Appointment Fees

Chapstick/Lip Balm

Contact Lens Insurance

Cosmetics

Cosmetic Surgery/Procedures

Dance/Exercise/Fitness Programs

Diaper Service

Electrolysis

Exercise Equipment

Eyeglass Insurance

Face Cream

Feminine Hygiene Products

Hair Loss Medications

Hair Transplant

Health Club Dues

Illegal Operation or Treatments

Insurance Premiums

Long Term Care Premiums

Marriage or Family Counseling

Massage Therapy\*

Maternity Clothes

Mattresses

Meals that are not part of inpatient care

Moisturizers

Nutritional Supplements\*

Personal Trainer

Prescription Drug Discount Programs

Prescription Drugs for Hair Loss

Provider Discounts

Rogaine

Shampoos/Soaps

Special Foods\*

Suntan Lotion/Sunscreen less than SPF 15

Supplements\* (*for general health*)

Teeth Whitening/Bleaching

Toiletries

Toothbrushes (*including battery operated*)

Toothpaste

Vision Discount Program Premiums

Vitamins\* (*for general health*)

Weight Loss Programs\* (*for general health*)



We make it easy.

P: 800 346 2126 | 608 831 8445

F: 608 831 4790

P.O. Box 44347

Madison, WI 53744-4347

An employee-owned company

[www.ebcflex.com](http://www.ebcflex.com)

\*Excludes drugs imported from Canada and other countries. Some medically necessary items may be covered by the Health Care FSA if prescribed by a physician for a specific medical condition. The prescription should contain the specific medical condition and timeframe for treatment.

\*\*Custom made shoes to treat or alleviate a specific medical condition. Included with the receipt should be a Letter of Medical Necessity from a physician. The excess cost above the normal cost of shoes is the eligible medical expense.

# My Account Assistant

## Login Instructions

### Account Login

1. Go to [www.ebcflex.com](http://www.ebcflex.com).
2. Click "Log In" **A** at the top of the page and choose "Participants."
3. Log in with your Username and Password.

### Create an Account

If you do not have a Username and Password, you will first need to register.

1. Click on the "Register" button **B**.
2. Fill out the short form and follow the on-screen instructions.

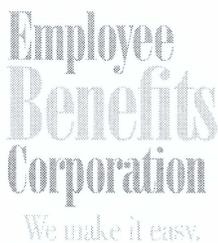
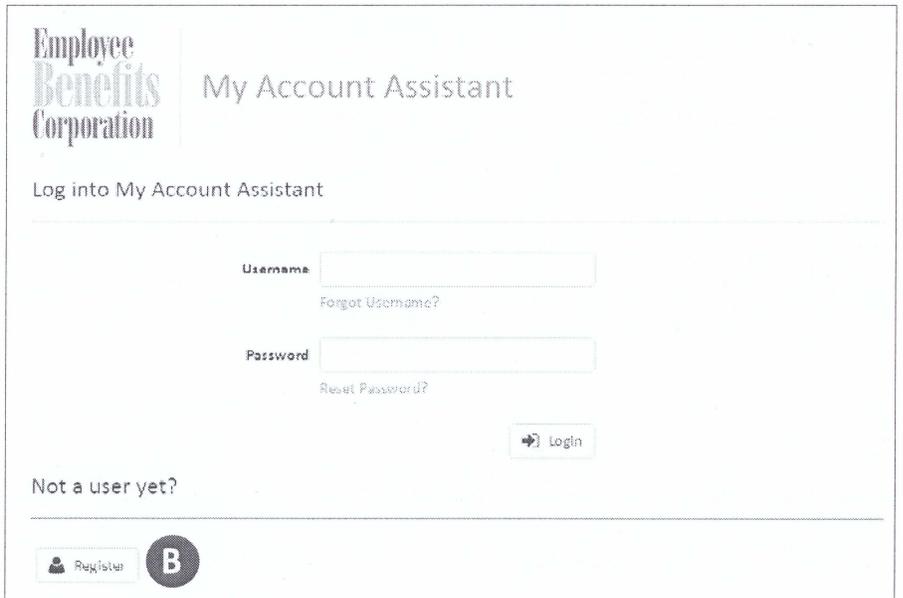
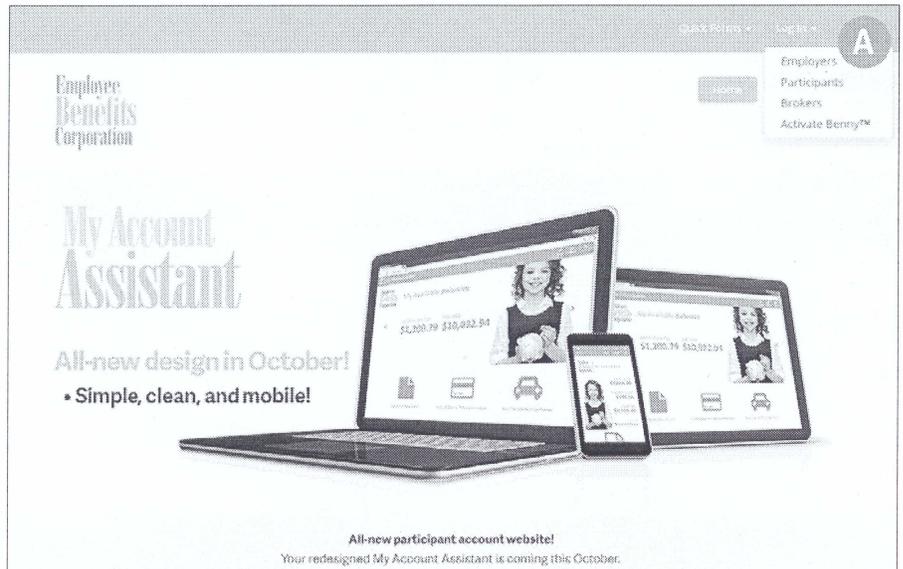
### Forgot your Username or Password?

To retrieve your login credentials:

1. At the log-in screen, click on "Forgot Username?" or "Reset Password?"
2. Enter your email address and click "Retrieve Username" or "Reset Password."
3. An email will be sent to you shortly with a link to your Security Question.
4. Provide the answer to your Security Question.
5. An email will be sent to you shortly with your Username included or instructions on how to reset your Password.

### Change your Username and Password

Once you log in, you may change your Username, Password, and Security Question. Simply open the menu and choose "My Security Settings" under "Change."



P: 800 346 2126 | 608 831 8445  
F: 608 831 4790  
P.O. Box 44347  
Madison, WI 53744-4347  
An employee-owned company  
[www.ebcflex.com](http://www.ebcflex.com)

### Questions?

If you have any questions, feel free to contact Participant Services at **800 346 2126**, or email [participantservices@ebcflex.com](mailto:participantservices@ebcflex.com).

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# My Account Assistant

## Submit a Claim *Online*

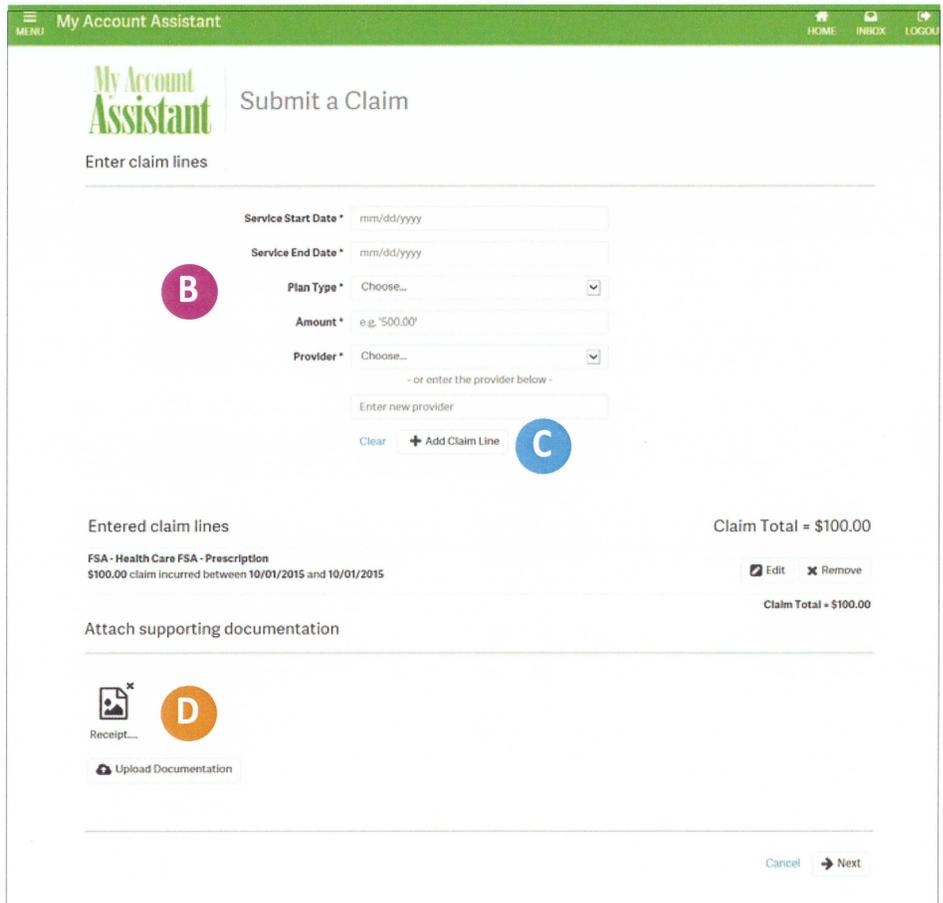
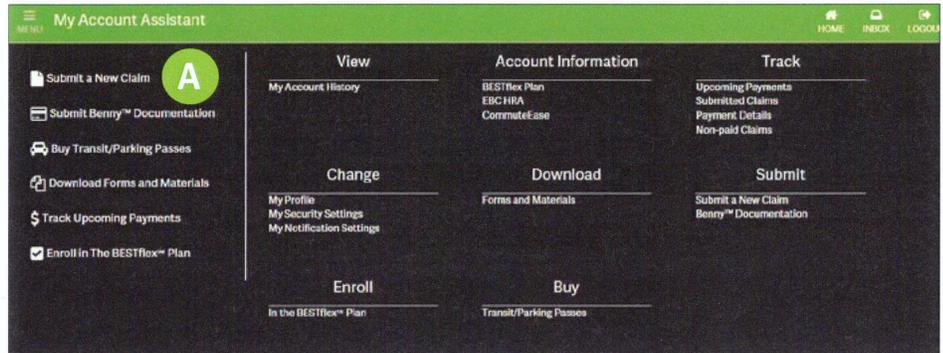
### Log In

1. Go to [www.ebcflex.com](http://www.ebcflex.com).
2. Click "Log In" at the top of the page and choose "Participants."
3. Log in to My Account Assistant with your Username and Password. To create an account, click on the "Register" button.

### Submit a New Claim

1. Open the menu and select "Submit a New Claim" **A**.
2. Complete the form **B** for an expense.
3. Click "Add Claim Line" **C** when done. Enter as many claim lines as you need.
4. Click "Upload Documentation" **D** to attach a scanned receipt, Explanation of Benefits (EOB), or other document that shows each expense is eligible.  

Your files must be less than 10 MB each. Click the "x" to remove a document.
5. Click "Next."
6. Review your claim lines and supporting documentation for accuracy.
7. Click "Submit" when ready.
8. Accept the Claim Submission Terms & Conditions in the pop-up box to finish.



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We make it easy.

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# HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

## In-Network or Out-of-Network Providers

In-Network: when seeking care in Wisconsin, select “*Blue Preferred*” network to verify provider participation; when seeking care outside of Wisconsin, select “*National PPO (BlueCard PPO)*” to verify provider participation.

Out-of-Network: any non- “*Blue Preferred*” or “*National PPO (BlueCard PPO)*” network provider.

## Pharmacy Provider

In-Network: eligible prescriptions processed through “*Express Scripts (ESI)*” retail and mail order pharmacy network.

Out-of-Network: any non-*Express Scripts (ESI)* retail or mail-order pharmacy.

**Attention Medicare Enrollees!** This plan does NOT qualify as a Medicare Part D Creditable Plan. Please read the HDHP’s *Medicare Part D Notice of Non-Creditable Coverage* and *Important Notice About Your Prescription Drug Coverage and Medicare* documents included in this guide to see how this may affect you.

## Points to Consider Regarding the High Deductible Health Plan (HDHP)

Before you enroll in the City of West Allis High Deductible Health Plan (HDHP), take a few moments to review the following.

- ✓ Make sure a High Deductible Health Plan (HDHP) is right for you and your family.
  - Understand how the plan works – review the deductibles, coinsurance and copays under the HDHP – know your exposure.
  
- ✓ Determine if you're eligible to participate in a Health Savings Account (HSA) in conjunction with the HDHP – *if ineligible to participate in an HSA, you may still participate in the HDHP.*
  - Ineligibility: an HSA is not available to individuals who participate in other health insurance (such as a spouse's plan or Medicare Parts A and/or B, Medicaid, Title 19), or are claimed as a dependent on someone else's tax return.
  
- ✓ Know and understand how a HSA works.
  - An HSA is an individual savings account, similar to an IRA, which allows you to set aside money to pay for current and future medical expenses.
  
  - Money used is tax-free when paying for qualified medical expenses.
  
  - The HSA account belongs to you; you decide how much money to place in the account. Maximum contributions in 2016, per the IRS, are \$3,350 for self-only coverage (\$4,350 for individuals age 55 and older), and \$6,750 for family coverage (\$7,750 for individuals age 55 and older). Contributions may be changed throughout the year up to the maximum allowed.
  
  - The City will be contributing \$500 towards a single plan or \$1,000 towards a couple or family plan into an HSA account for eligible HSA plan participants for this plan year, 3-1-16 to 2-28-17.
  
- ✓ This plan does NOT qualify as a Medicare Part D Creditable Plan. Please read the HDHP's *Medicare Part D Notice of Non-Creditable Coverage and Important Notice About Your Prescription Drug Coverage and Medicare* documents included in this guide to see how this may affect you.



## HDHP BENEFIT SUMMARY - ACTIVE EMPLOYEES

This document is meant as a summary description of basic benefit coverage. It cannot add to or take away from any legal plan. This document describes the benefit program in general terms. It is not intended to be a complete description of coverage.

**THE CITY'S HEALTH INSURANCE PLAN HAS THE FOLLOWING EXCLUSIONS:** Dental care, cosmetic surgery unless medically necessary, eyeglasses, contact lenses, dentures, hearing aids for adults, custodial or domiciliary care, experimental medical procedures, examinations for employment, sports or purchase of insurance, care required while in government operated facility or services required while incarcerated or in military service. Refer to your Benefit Booklet for further details.

	<b>IN NETWORK SERVICES</b>	<b>OUT OF NETWORK SERVICES</b>
	<p>ANTHEM <i>Blue Preferred</i> provider network for services <u>in</u> Wisconsin.</p> <p>ANTHEM <i>National PPO (BlueCard PPO)</i> provider network for services <u>outside of</u> Wisconsin.</p>	
<b>MAXIMUM COVERAGE</b>	<p>No dollar limit.</p> <p><i>Payment of services will depend on how providers bill.</i></p>	<p>No dollar limit.</p> <p><i>Payment of services will depend on how providers bill.</i></p>
<b>DEDUCTIBLE</b>	<p>Unless otherwise noted, deductibles of \$1,500 per person or \$3,000 per couple or family per Plan year for combined medical and prescription drug services (excludes Routine Preventative services).</p>	<p>Unless otherwise noted, deductibles of \$15,000 per person or \$30,000 per couple or family per Plan year for combined medical and prescription drug services.</p>
<b>COINSURANCE (PERCENT OF COVERED CHARGES)</b>	<p>80% of eligible charges after applicable deductible has been satisfied and until out-of-pocket limit is reached (excludes eligible Routine Preventative services).</p>	<p>Unless otherwise noted, the Plan pays 60% of medically necessary/eligible services after the deductible has been satisfied.</p>
<b>ANNUAL OUT-OF-POCKET (LIMIT ON EXPENSES)</b>	<p>Maximum out-of-pocket coinsurance (including the deductible) is \$3,000 for a single plan participant or \$6,000 for a couple or family plan participant per Plan year; thereafter, the Plan pays 100% of eligible charges.</p>	<p>Maximum out-of-pocket coinsurance (including the deductible) is \$30,000 per person or \$60,000 per family per Plan year; thereafter, the Plan pays 100% of medically necessary/eligible services.</p>
<p><b>ROUTINE PREVENTATIVE CARE:</b></p> <p>Women's Health Services;            Routine Adult Physicals;            Well Child Care;            Immunizations (Child &amp; Adult);            Flu Shots;            Diagnostic X-Rays and Lab Tests;            Colon Cancer Screening;            Prostate Cancer Screening;            Pap Smear;            Mammography;            Vision &amp; Hearing Exams</p>	<p>100% of eligible charges; deductible/copay is waived.</p>	<p>Not covered.</p>
<b>HOSPITALIZATION</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>PHYSICIAN VISITS IN HOSPITAL</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>SURGICAL CARE OR SURGERY</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>EMERGENCY CARE</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>AMBULANCE</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.

HDHP Benefit Summary - Active Employees

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
URGENT CARE FACILITY	80% of eligible charges after deductible.	60% of eligible charges after deductible.
PHYSICIAN OFFICE VISITS (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
DIAGNOSTIC X-RAY, LAB SERVICES (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
INJECTIONS	80% of eligible charges after deductible.	60% of eligible charges after deductible.
ALLERGY CARE	80% of eligible charges after deductible.	60% of eligible charges after deductible.
PODIATRY SERVICES (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
HEARING EXAM (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
EYE EXAM (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
MATERNITY	80% of eligible charges after deductible.	60% of eligible charges after deductible.
PEDIATRIC CARE (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
HEALTH EDUCATION & COUNSELING (Non-Routine)	80% of eligible charges after deductible.	60% of eligible charges after deductible.
ORAL SURGERY	80% of eligible charges after deductible for initial treatment for injury to sound, natural teeth and for specific diseases, including removal of partially or completely unerupted impacted teeth.	60% of eligible charges after deductible for initial treatment for injury to sound, natural teeth and for specific diseases, including removal of partially or completely unerupted impacted teeth.
MENTAL HEALTH & ALCOHOL/ SUBSTANCE ABUSE:  Inpatient, Residential  Outpatient Therapy and Office Visit Services  Partial Hospitalization	80% of eligible charges after deductible.  80% of eligible charges after deductible.  80% of eligible charges after deductible.	60% of eligible charges after deductible.
<p><b>NOTE:</b> The City offers an Employee Assistance Program (EAP), administered by Aurora, in addition to the coverage provided under this insurance program; it is a separate and FREE benefit. For further information, contact the Aurora Employee Assistance Program at (800) 236-3231 OR the City's Human Resources Department at (414) 302-8270.</p>		
CHIROPRACTIC CARE	80% of eligible, medically necessary charges after deductible.  <i>Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.</i>	60% of eligible, medically necessary charges after deductible.
PHYSICAL THERAPY	80% of eligible, medically necessary charges after deductible.  <i>Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.</i>	60% of eligible, medically necessary charges after deductible.
OCCUPATIONAL THERAPY	80% of eligible, medically necessary charges after deductible.  <i>Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.</i>	60%, of eligible, medically necessary charges after deductible.

HDHP Benefit Summary - Active Employees

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
<b>THERAPIES – CARDIAC, CHEMO, DIALYSIS/ HEMODIALYSIS, INFUSION RADIATION, AND RESPIRATORY (Inpatient/Outpatient)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>DURABLE MEDICAL EQUIPMENT</b>	80% of eligible charges after deductible for initial purchase or rental when authorized; does not cover repair or replacement.	60% of eligible charges after deductible for initial purchase or rental when authorized; does not cover repair or replacement.
<b>PRESCRIPTION DRUGS</b>	80% of charges per prescription or refill after deductible.  <b>Retail Network Provider: Express Scripts Mail Order Provider: Express Scripts</b>	60% of charges per prescription or refill after deductible.
<b>DEPENDENT COVERAGE</b>	Refer to the last page of this document for details.	
<b>COORDINATION OF BENEFITS</b>	Benefits under this Plan are coordinated with benefits provided by other plans for which you and/or your dependents are also covered. Refer to the <i>Coordination of Benefits</i> section in your Benefit Booklet for details.	
<b>PRE-CERTIFICATION</b>	Required for Non-emergency Inpatient Hospital Admissions (includes Mental Health, Alcohol/Substance Abuse), Surgical Procedures, Outpatient Care, Skilled Nursing Facility, Home Health Care, and Hospice Care.	

The City reserves the right to make changes to coverage if future non-discrimination testing rules or plan structure makes it impossible to provide coverage.

## HDHP Benefit Summary - Active Employees

**Dependent** means a covered **employee's**:

1. Legally recognized spouse;
2. Natural blood related child, step-child, legally adopted child or a child under **your** legal guardianship as determined with a court decree whose age is less than the limiting age. Each child must legally qualify as a **dependent** as defined by the United States Internal Revenue Service guidelines or applicable State Statutes.

**Limiting age and eligibility criteria:**

**Dependent children under age 26 (as required by federal and state mandates):**

The limiting age for each **dependent** child is the end of the month he or she attains the age of 26 years, regardless if the child is:

- a. Married;
- b. A tax dependent;
- c. A student;
- d. Employed;
- e. Residing with or receives financial support from *you*; or
- f. Eligible for other coverage through employment.

**Dependent child, age 26 and older (as required by State mandate), who is called to federal active duty:**

The limiting age is any age for each **dependent** child age 26 and older when they meet the requirements outlined below. **Dependent** termination is the end of the month they no longer meet these requirements.

- The child is a full-time student; and
  - The child was 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 an institution of higher education on a full-time basis; and
  - The child was under age 27 when called to federal active duty; and
  - The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; and
  - If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.
3. A covered **employee's** child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
  4. Grandchild, as long as the **employee's** covered **dependent**, who is the parent of the grandchild, is not yet age 18.

**You** must furnish satisfactory proof to the **City** upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

A covered **dependent** child who attains the limiting age while covered under the Plan will remain eligible for medical benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a **dependent** as determined by the United States Internal Revenue Service;
4. Unmarried.

**You** must furnish satisfactory proof to the **City** that the above conditions continuously exist on and after the date the limiting age is reached. The **City** may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

# Finding In-network Providers in the High Deductible Health Plan (HDHP)

## [www.Anthem.com](http://www.Anthem.com)

Locating in-network providers is dependent upon your location at the time you are seeking care:

- ✓ select “**Blue Preferred**” when seeking care in Wisconsin;
- ✓ select “**National PPO (Bluecard PPO)**” when seeking care outside of Wisconsin.

To begin your search, log into [www.anthem.com](http://www.anthem.com)

1. Select “Find A Doctor” on the right-hand side of the screen.
2. Under “Search as a Guest” select “Search by Selecting a Plan or Network” (DO NOT choose “CONTINUE”).
3. For “What type of care are you searching for?” choose Medical.
4. For “What state do you want to search in?” choose whichever state you will be receiving services.
5. For “Select a plan/network” choose the *Blue Preferred* network under the “Medical Networks” option for services in Wisconsin; choose the *National PPO (BlueCard PPO)* network under the “Medical Employer-Sponsored” option for services in any state other than Wisconsin.
6. Select “Continue”.
7. The next screen will allow you to select the following:
  - a. Type of Provider
  - b. Enter Name of Provider (not required)
  - c. Demographic Information (City and State)
8. Click “Search”. A list with the selected type of providers in your demographic area will appear.

**Questions? Contact Anthem at 844-286-6371**

# PreventiveRx

PreventiveRx is a prescription drug benefit administered by Anthem and available to individuals who enroll in the High Deductible Health Plan (HDHP). This program allows members to receive certain preventive drugs at no cost.

In many cases, preventive drugs can help individuals lead healthier lives. The PreventiveRx drug list has medications proven to help avoid illness, complications and other health issues, which in turn may lead to fewer hospitalizations, doctor visits and missed days of work.

The PreventiveRx Plus drug list (refer to following pages) includes more than 200 drugs to treat conditions such as:

- Asthma
- Blood clots
- Diabetes
- Heart health
- High blood pressure
- High cholesterol
- Osteoporosis
- Stroke

# PreventiveRx<sup>SM</sup> Drug List: PreventiveRx Plus Plan



PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.

This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Brand-name drugs that have a generic equivalent available are not covered under this Preventive Rx benefit.

All drugs listed below are covered for plans with the National Drug List. If your plan has a different drug list, please check to see if these drugs are included on your drug list. PreventiveRx Plus drugs are only covered if they are included on your specific drug list.

## Asthma

Advair  
Advair HFA  
albuterol sulfate  
aminophylline  
Arnuity Ellipta  
Asmanex  
Asmanex HFA  
Breo Ellipta  
budesonide  
cromolyn sodium  
Dulera  
dyphylline  
dyphylline/ guaifenesin  
elixophylline  
Flovent Diskus  
Flovent HFA  
Foradil  
levalbuterol  
metaproterenol sulfate  
montelukast  
Perforomist  
ProAir HFA  
Pulmicort Flexhaler  
QVAR  
Serevent Diskus  
Symbicort  
terbutaline sulfate  
Theo- 24  
Theochron  
theophylline  
Ventolin HFA  
zafirlukast

## Blood clots

Brilinta  
Coumadin  
Eliquis  
heparin  
Pradaxa  
warfarin  
Xarelto

## Diabetes

*Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips by Lifescan & Roche will be covered by this benefit.*

acarbose  
ActoPlusMet XR  
Bydureon  
Byetta  
chlorpropamide  
glimepiride  
glipizide  
glipizide er/xl  
glipizide with metformin hcl  
glyburide  
glyburide with metformin hcl  
glyburide, micronized  
Glyset  
Humalog  
Humulin  
Janumet  
Janumet XR  
Januvia  
Jentadueto  
Juvisync  
Lantus  
Levemir  
metformin hcl  
metformin hcl er  
nateglinide  
Novolin  
Novolog  
pioglitazone  
pioglitazone- glimepiride  
pioglitazone- metformin  
repaglinide

## Symlin

tolazamide  
tolbutamide  
Tradjenta  
Victoza

## Heart health and high blood pressure

acebutolol hcl  
acetazolamide  
afeditab cr  
amiloride hcl  
amiloride/ hctz  
amlodipine besylate  
amlodipine/ benazepril  
amlodipine/ valsartan  
amlodipine/ valsartan/ hctz  
atenolol  
atenolol/ chlorthalidone  
benazepril hcl  
benazepril hcl/ hctz  
betaxolol hcl  
Bidil  
bisoprolol fumarate  
bisoprolol fumarate/ hctz  
bumetanide  
candesartan  
candesartan/ hctz  
captopril  
captopril/ hctz  
cartia xt  
carvedilol  
chlorthiazide  
chlorthalidone  
clonidine hcl  
Clorpres 0.1, 0.2mg  
Coreg CR  
digitek  
digoxin  
Dilatrate SR  
dilt-cd  
diltia XT

diltiazem hcl  
diltiazem hcl er  
doxazosin mesylate  
enalapril maleate  
enalapril/ hctz  
eplerenone  
eprosartan  
felodipine er  
fosinopril sodium  
fosinopril/ hctz  
furosemide  
guanfacine hcl  
hydralazine hcl  
hydrochlorothiazide  
indapamide  
irbesartan  
irbesartan/ hctz  
Isordil 40mg  
isosorbide dinitrate  
isosorbide dinitrate er  
isosorbide mononitrate  
isosorbide mononitrate er  
isradipine  
labetolol hcl  
Lanxoin  
lisinopril  
lisinopril/ hctz  
losartan  
losartan/ hctz  
Matzim LA  
methazolamide  
methyldopa  
methyldopa/ hctz  
metolazone  
metoprolol succinate er  
metoprolol tartrate  
metoprolol/ hctz  
minoxidil  
moexipril hcl  
moexipril/ hctz

PreventiveRx<sup>SM</sup> Drug List:  
PreventiveRx Plus Plan



nadolol  
nadolol/  
bendroflumethiazide  
nicardipine hcl  
nifedipine  
nifedipine er  
nimopidine  
nisoldipine  
Nitro-Bid  
Nitro-Dur 0.3, 0.8mg/  
hr  
nitroglycerin  
nitroglycerin 400 mcg  
spray  
nitroglycerin er  
nitroglycerin lingual  
nitroglycerin spray  
Nitrostat  
perindopril  
pindolol  
prazosin hcl  
propranolol hcl  
propranolol hcl er  
propranolol/ hctz  
quinapril hcl  
quinapril/ hctz  
ramipril  
Ranexa  
reserpine  
sotalol hcl  
sotalol hcl af  
spironolactone  
spironolactone/ hctz

Taztia XT  
telmisartan  
telmisartan/  
amlodipine  
telmisartan/ hctz  
terazosin hcl  
thalitone  
timolol maleate  
torsemide  
trandolapril  
trandolapril/  
verapamil  
triamterene/ hctz  
valsartan  
valsartan/ hctz  
Valturna  
verapamil hcl  
verapamil hcl er

**High cholesterol**  
Advicor  
atorvastatin  
atorvastatin/  
amlodipine  
cholestyramine  
cholestyramine light  
colestipol hcl  
Crestor  
fenofibrate (43, 67,  
130, 134, 200 mg  
capsules & 48, 54,  
145, 160mg tablets)  
fenofibric acid

fluvastatin  
gemfibrozil  
lovastatin  
niacin ER  
omega- 3 ethyl ester  
1 gm capsule  
pravastatin  
Prevalite  
simvastatin  
Welchol

**Osteoporosis**  
alendronate sodium  
calcitonin- salmon  
Climara Pro  
Combipatch  
covaryx  
covaryx HS  
est. estrogens with  
methyltestosterone  
estradiol tab, patch  
estradiol/  
norethindrone  
acetate  
estropipate  
Femtrace  
fortical  
Fosamax Plus D  
ibandronate sodium  
tablets  
Jevantique  
Jenteli

medroxyprogesterone  
acetate  
Menest  
norethindrone- ethin  
estradiol  
Premarin tablets  
Premphase  
Prempro  
raloxifene  
risedronate

**Stroke**  
aspirin-dipyridamole  
ER  
cilostazol  
clopidogrel bisulfate  
dipyridamole  
Effient  
ticlopidine

## HIGH DEDUCTIBLE HEALTH PLAN (HDHP) MEDICARE PART D NOTICE OF NON-CREDITABLE COVERAGE

In December of 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act. One of the benefits of this law is to give all Medicare eligible individuals the right, and the availability, to participate in a government sponsored prescription drug plan. The prescription drug plan is known as **Medicare Part D**. The effective date for Medicare Part D was January 1, 2006.

One of the requirements of this legislation is that an employer must inform its Medicare eligible employees whether the prescription drug coverage they have available under the employer's health plan or prescription drug plan, is creditable coverage or non-creditable coverage. This requirement is met by an employer providing a specific Notice of Creditable Coverage or Notice of Non-Creditable Coverage.

- **Creditable coverage** is prescription drug coverage which is expected to pay out at least as much, or greater than, the Medicare Part D prescription drug plan will pay.
- **Non-creditable coverage** is prescription drug coverage which is NOT expected to pay out as much as the Medicare Part D prescription drug plan will pay.

The **difference** between creditable coverage and non-creditable coverage is **very important to you**. If you are currently covered under a prescription drug plan which has non-creditable coverage and are **eligible to enroll in Medicare Part D but choose not to do so**, you may be charged at minimum, a **1% premium surcharge** for every month you were eligible to enroll in Part D, but did not enroll. **However, if you can show that you were covered by a prescription drug plan that had creditable coverage, then this premium surcharge will be waived** at the time of enrollment in Medicare Part D.

Therefore, this is to inform you that as a participant in the City of West Allis's High Deductible Health Plan (HDHP) it has been determined that you have **non-creditable prescription drug coverage**. This information is not only important to you, but to your spouse and/or dependents covered under the City's plan(s) who may be Medicare eligible.

Following is the City's Notice of Non-Creditable Coverage. **This is a very important document and should be kept in a secure place**. It contains more information about your non-creditable coverage and Medicare Part D.

For more information on the Medicare Part D program and/or your eligibility for coverage, visit [www.medicare.gov](http://www.medicare.gov) for personalized help or call 800-MEDICARE, 800-633-4227. TTY users should call 877-486-2048.

If you have any questions regarding this communication please do not hesitate to contact Jane Barwick, Principal Human Resources Analyst, at 414-302-8272 (M-F, 7:30 AM – 4:00 PM) or Audrey Key, Human Resources Director, at 414-302-8274 (M-F, 8:30 AM – 5:00 PM).

## HIGH DEDUCTIBLE HEALTH PLAN (HDHP) IMPORTANT NOTICE ABOUT YOUR 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 the City of West Allis High Deductible Health Plan 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. The City of West Allis has determined that the prescription drug coverage offered by the City's High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the City of West Allis High Deductible Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the City of West Allis High Deductible Health Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

---

### 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 15<sup>th</sup> through December 7<sup>th</sup>**. However, if you decide to drop your current coverage with the City of West Allis, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the City of West Allis Plan.

Since you participated previously in the City of West Allis PPO Plan and are now losing creditable prescription drug coverage under the City of West Allis High Deductible Health Plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the coverage under the City's High Deductible Health Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## **What Happens To Your Current Coverage If You Decide To Join A Medicare Part D Drug Plan?**

If you decide to join a Medicare drug plan, your current City of West Allis coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current City of West Allis coverage, be aware that you and your dependents may not be able to get this coverage back.

## **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact Jane Barwick, Principal Human Resources Analyst, at 414-302-8272 (M-F, 7:30 AM – 4:00 PM) or Audrey Key, Human Resources Director, at 414-302-8274 (M-F, 8:30 AM – 5:00 PM)

**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 the City of West Allis 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](http://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 800-MEDICARE, 800-633-4227. TTY users should call 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](http://www.socialsecurity.gov), or call them at 800-772-1213; TTY 800-325-0778.

**Remember: Keep this notice of Non-Creditable Coverage. 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 whether or not you are required to pay a higher premium (a penalty).**

Date: January 25, 2016

Name of Entity/Sender: City of West Allis/Human Resources Department

Contact--Position/Office: Jane Barwick (Principal Human Resources Analyst) or Audrey Key (Human Resources Director)

Address: 7525 W. Greenfield Avenue, West Allis, WI 53214

Main Office Phone Number for the City's Human Resources Department: 414-302-8270

This notice will be distributed annually with the insurance open enrollment information; copies may be requested at any time.

## HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is an individual savings account, similar to an IRA, that allows you to set money aside to pay for current and future medical expenses. The money you deposit into the account is not taxed, as long as you use it for qualified medical expenses. The program is administered by Tri-City National Bank, 888-874-2489; [www.tcnb.com](http://www.tcnb.com).

1. You may participate in an HSA if you enroll in Anthem's High Deductible Health Plan (HDHP).

This plan option is not available to employees who elect participation in Anthem's PPO "Blue Priority" Health Plan OR for those who participate in other health insurance [such as a spouse's plan or Medicare Parts A and/or B, Medicaid, Title 19], or are claimed as a dependent on someone else's tax return.

2. The City will contribute \$500 towards a single plan or \$1,000 towards a couple or family plan (prorated monthly) into an HSA account for plan year 3-1-16 to 2-28-17. (Note: The combined employer and employee contributions for 2016 may not exceed \$3350 for self-only coverage [\$4350 for individuals age 55 and older] and \$6750 for family coverage [\$7750 for individuals age 55 and older]).
3. Employees wishing to enroll in a Health Savings Account MUST complete Tri-City National Bank's HSA Application Information Form along with the City's Health Savings Account (HSA) for Direct Deposit form and return to the Finance Department **NO LATER THAN 5 p.m. Wednesday, February 10, 2016.**

## **HOW DOES A HEALTH SAVINGS ACCOUNT (HSA) WORK?**

A Health Savings Account (HSA) must be used in conjunction with a qualified High Deductible Health Plan (HDHP). To qualify as a HDHP, a health plan must satisfy certain IRS requirements for a minimum annual deductible and maximum out-of-pocket expenses. (In 2016, the minimum annual deductible for a qualifying HDHP is \$1,300 for an individual and \$2,600 for a couple/family. The maximum out-of-pocket limits for 2016 are \$6,550 for self-only coverage and \$13,100 for couple/family coverage.)

With an HSA, you can make pre-tax or after-tax contributions to an account owned by you to pay for current and future medical expenses. Funds in the account earn interest tax free and you don't pay taxes on withdrawals as long as the monies are used to pay for qualified medical expenses.

Your eligibility to contribute to an HSA is determined monthly. You must have HDHP coverage on the first day of the month to make an HSA contribution for that month.

## **WHAT ARE THE ADVANTAGES OF AN HSA?**

An HSA provides you with triple tax savings:

1. Tax deductions when you contribute to your account
2. Tax-free earnings through investment
3. Tax-free withdrawals for qualified medical expenses

You can use your HSA to pay for current medical expenses, including your deductible and expenses that your insurance may not cover, or you can save your funds for future medical expenses, such as:

- Health insurance or medical expenses if unemployed
- Medical expenses after retirement (before Medicare)
- Out-of-pocket expenses when covered by Medicare
- Long-term care expenses and insurance

Your HSA balance can be carried over from year to year. What you don't use in any given year will stay invested and continue to grow tax-free. Upon retirement, employees may continue to use their HSA funds tax-free if the funds are used to pay for qualified medical expenses.

## **WHO CONTROLS THE ACCOUNT?**

You make the decisions regarding:

- how much money you will put in the account;
- when to make contributions to the account;
- whether to save the account for future expenses or pay current medical expenses;
- which expenses to pay for from the account; and,
- how to invest the money in the account.

Accounts are completely portable, meaning you can keep your HSA even if you change jobs, change your medical coverage, become unemployed, or move to another state.

### **HOW MUCH CAN BE CONTRIBUTED TO THE ACCOUNT?**

Maximum contributions in 2016 per the IRS are \$3,350 for self-only coverage (\$4,350 for individuals age 55 and older), and \$6,750 for family coverage (\$7,750 for individuals age 55 and older). For each month that you are eligible, you can contribute up to one-twelfth of the annual maximum.

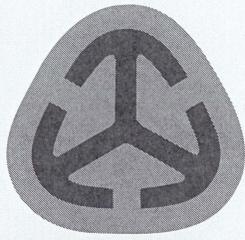
### **CAN I CHANGE MY ELECTION AT ANY TIME?**

Yes, you may change your election amount at any given time throughout the year; however you can contribute no more than the designated annual maximum.

### **CAN THE HSA MONEY BE WITHDRAWN FOR PURPOSES OTHER THAN MEDICAL EXPENSES?**

Yes, you may withdraw money from your HSA at any time and for any reason; however, if your HSA money is not used for medical expenses, you will have to pay income tax on your withdrawal. You will also have to pay a 20 percent additional tax, unless the withdrawal is made after you attain age 65, become disabled, or after your death.

Questions or concerns regarding Health Savings Accounts may be directed to Tri-City National Bank, 888-874-2489; [www.tcnb.com](http://www.tcnb.com) or the City's Finance Department at 414-302-8260.



**TRI CITY  
NATIONAL  
BANK**

# Health Savings Account

For City of West Allis Employees

## Benefits

- No Account Opening Fee
- First Box of Checks Free
- Free Debit Card with No Inactivity Period
- Free Online Banking to Review Your Account Activity
- Unlimited Debit Card Transactions
- 10 Checks Per Month
  - \$1 Per Check Written Over 10

## Tiered Interest Rates

- \$0 - \$9,999
  - \$10,000 - \$24,999
  - \$25,000+
- \*Ask us for our current rates

## Minimum Balance Requirements

- Fee is waived for 2016
- Fee is waived permanently for Retirees
- After 2016, fee is waved with any of the following:
  - \$1,000 minimum balance
  - Monthly automatic payroll contributions
  - A minimum balance of \$2,500 in related TCNB accounts
- After 2016, there will be a \$4 fee per month if none of these are applicable

## Our West Allis Locations

10909 W. Greenfield Ave.  
(414) 476-4500

6767 W. Greenfield Ave.  
(414) 453-7410

2625 S 108th St., inside *Pick'n Save*  
(414) 543-3710

6760 W National Ave., inside *Pick'n Save*  
(414) 771-0410

[www.tcnb.com](http://www.tcnb.com) • 1-888-TRI-CITY (874-2489)

Member  
**FDIC**



**INFORMATION APPLICABLE TO  
BOTH HEALTH PLANS  
(PPO PLAN and the HDHP)**



# Register with anthem.com to access your benefits\*



From your computer



Go to **anthem.com** and select **Register Now**



Provide the personal information requested



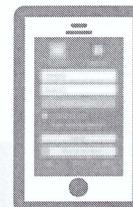
Create a username and password



Set your email preferences



Select **Submit**



From your mobile device



Search for **Anthem Blue Cross and Blue Shield** in your app store and select **Install (It's free)**. Open the app and select **Register Now**



Confirm your identity



Create a username and password



Set your email preferences



Confirm and select **Register**

**Need help signing up?**

Call the Help Desk at  
**1-866-755-2680.**



\* You must be 18 years or older to register your own account.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado and Nevada: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare"), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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# You have choices

that can save you a lot

## Estimate your health care costs and see your options

Sometimes, the cost of health care can be more than what you expect when you need a procedure, service or lab work. But when you know what your cost will be ahead of time, you can plan ahead. With our Estimate Your Cost tool, you can find out costs and compare facilities and providers based on cost and quality ratings for procedures — before you get them. It puts you in control of where and how you spend your health care dollars.

## Don't pay too much

Use the Estimate Your Cost tool to **get an idea of what you'll pay** before you get a procedure.

Peace of mind comes when you plan ahead. The Estimate Your Cost tool was designed to help you feel better about where you go for care.

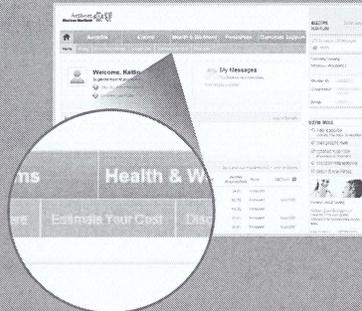


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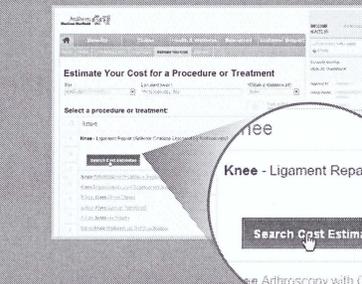
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## The Estimate Your Cost tool is easy to use

Just follow these steps to get the information you want:

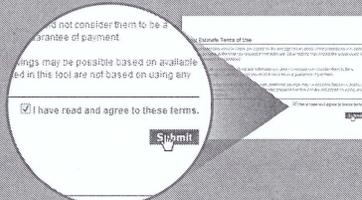


1. Log in to **anthem.com**.

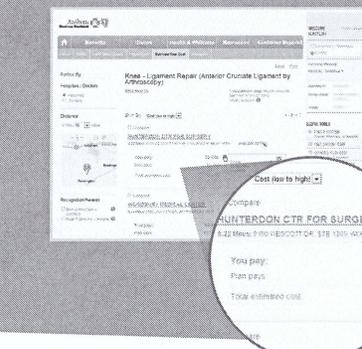


2. Choose **Estimate Your Cost**.

3. Enter the location you want, how far you want to travel and the procedure needed. Then, choose **Search Cost Estimates**.



4. Agree to the **Terms of Use** and choose **Submit**.



5. Take a look at the list of providers in our network and the estimated costs for the procedure.

# Take care of yourself. Use your preventive care benefits.

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.<sup>1</sup> When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

## Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

## Child preventive care

### Preventive physical exams

#### Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening<sup>2</sup> when done as part of a preventive care visit

#### Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

## Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met<sup>3</sup>
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)<sup>4,5</sup>
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening<sup>5</sup>
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV<sup>5</sup>
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

*This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.*

## Adult preventive care

### Preventive physical exams

#### Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision<sup>2</sup>
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years<sup>6</sup>
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

#### Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

## A word about pharmacy items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not “need” a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

#### Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old
- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 6-12 months

#### Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older

#### Women’s preventive drugs and other pharmacy items — age appropriate:

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides<sup>5,7</sup>
- Folic acid for women 55 years old or younger
- Vitamin D for women over 65
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)<sup>6</sup>

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your *Certificate of Coverage* or call the Customer Service number on your ID card.

2 Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.

3 Check your medical policy for details.

4 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

5 This benefit also applies to those younger than 19.

6 You may be required to get prior authorization for these services.

7 A cost share may apply for other prescription contraceptives, based on your drug benefits.

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Check how much your medicine will cost you.

## Now it's easy to find the best price on your prescription drugs.

Did you know that the same prescription drug can cost more at one pharmacy than another — and can change from one week to the next?

For many reasons, drug prices rise and fall. The price of a drug may go down if lots of similar drugs are available, and may be expensive if the drug is unique. Sometimes drug makers must change the price because their costs go up or down. And pharmacies may change prices based on their contracts with drug makers. Plus, some pharmacies offer promotions or discounts from time to time that can help you save.

### Got a few minutes? Save a few dollars.

You could save money by comparing prices and finding the lowest cost. Usually, you'll save the most by choosing generic drugs, and possibly save more by using our preferred home delivery pharmacy, managed by Express Scripts.

### Three easy ways to check prices on your prescription drugs:

#### 1. Go to [anthem.com](http://anthem.com)

- Under Useful Tools, choose **Prescription Benefits** and log in to your account.
- In the Pharmacy Benefits section, select **Price a Medication**. You will be redirected to [express-scripts.com](http://express-scripts.com).
- In the space provided, enter at least the first three (3) letters of the drug name and click **Search**.
- Select your drug, including the proper dosage, and click **Continue**.
- Fill in the information for quantity, days' supply and reason for brand drug preference (if asked), then click **Continue**.
- View the results displayed, which will show you what you pay for the drug at a retail pharmacy vs. our preferred home delivery pharmacy.

#### 2. Visit your pharmacy.

Before filling your prescription, your pharmacist can tell you how much it will cost. If you think the cost is too high, talk to your doctor about other options.

#### 3. Call us.

You can get a price quote by calling the phone number on your member ID card. Simply provide:

- Drug name
- Strength
- Form (such as tablet or capsule)
- Quantity and days' supply (for example, 30 tablets per 30 days)



\*Express Scripts is the company that manages the operations of your drug plan. The first time you're directed to the Express Scripts website, you'll go through a brief registration. The purpose is to set your preferences for email and privacy. You'll do this only once. Please do not go directly to the Express Scripts website. The only way to make sure you're viewing your pharmacy information correctly is by logging in to [anthem.com](http://anthem.com) first.

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# Getting started with Home Delivery Pharmacy

If you take prescribed medicine on a regular basis, you can get up to a 90-day supply mailed right to your door.\* Here's how to start:

## Step one

### Create your account and print your order form

There are two ways to do this:

- Log on to your health plan's website.
  - Register at your health plan website if you haven't done so.
  - Click **Prescription Benefits** in the *Useful Tools* box.
  - Click **Start a New Prescription**.

This takes you to the Express Scripts website. You can find out how to:

- Print an order form to mail in with your prescription.
- Print a fax form to take to your doctor to fax in your prescription.
- See how much your medicine will cost.

## Step two

### See your doctor for a prescription for a 90-day supply of your medicine

You'll need a 90-day supply prescription for your first Home Delivery Pharmacy order. But you should also ask your doctor to write you another prescription for a 30-day supply. This is so you can get the 30-day supply filled at your local pharmacy while your first Home Delivery order is being processed.

- Your doctor can give you a prescription to mail in with your order form.
- Or, the doctor can fill out the physician fax form and fax it to the phone number on the form.

If your doctor prescribes a brand-name drug, your plan design may require the Home Delivery Pharmacy to substitute the generic version instead.

## Step three

### Paying for your prescription

You can pay by e-check, check, money order or credit card. Make checks and money orders payable to Express Scripts, and write your member ID number on the front. You can enroll in e-check payments, have credit cards on file through the website or call the number on your member ID card.

## Step four

### Send us your prescription

You can send us your prescription in two ways:

- **Mail:** Fill out the order form and mail it with the prescription and payment (if you're using a check/money order) to the address listed on the form. Please fill out payment information on the form if you're not using a check/money order.
- **Fax:** Your doctor can complete the physician fax form and fax it to the phone number on the form.

All prescriptions and refills, including those sent in by your doctor, are processed as soon as they are received. Please don't send in your prescription unless you are ready to have it filled.

## Important to know

Your medicine will be sent to your home within two weeks from the time the Home Delivery Pharmacy gets your order. If you need your medicine sooner, call the number on your ID card to ask for your order to be sent overnight. Please allow three to five days for processing plus the shipping time. You will be charged an additional fee. Your order will be sent through the post office, UPS or FedEx. Please note, with some medicines, you may have to sign to accept delivery.

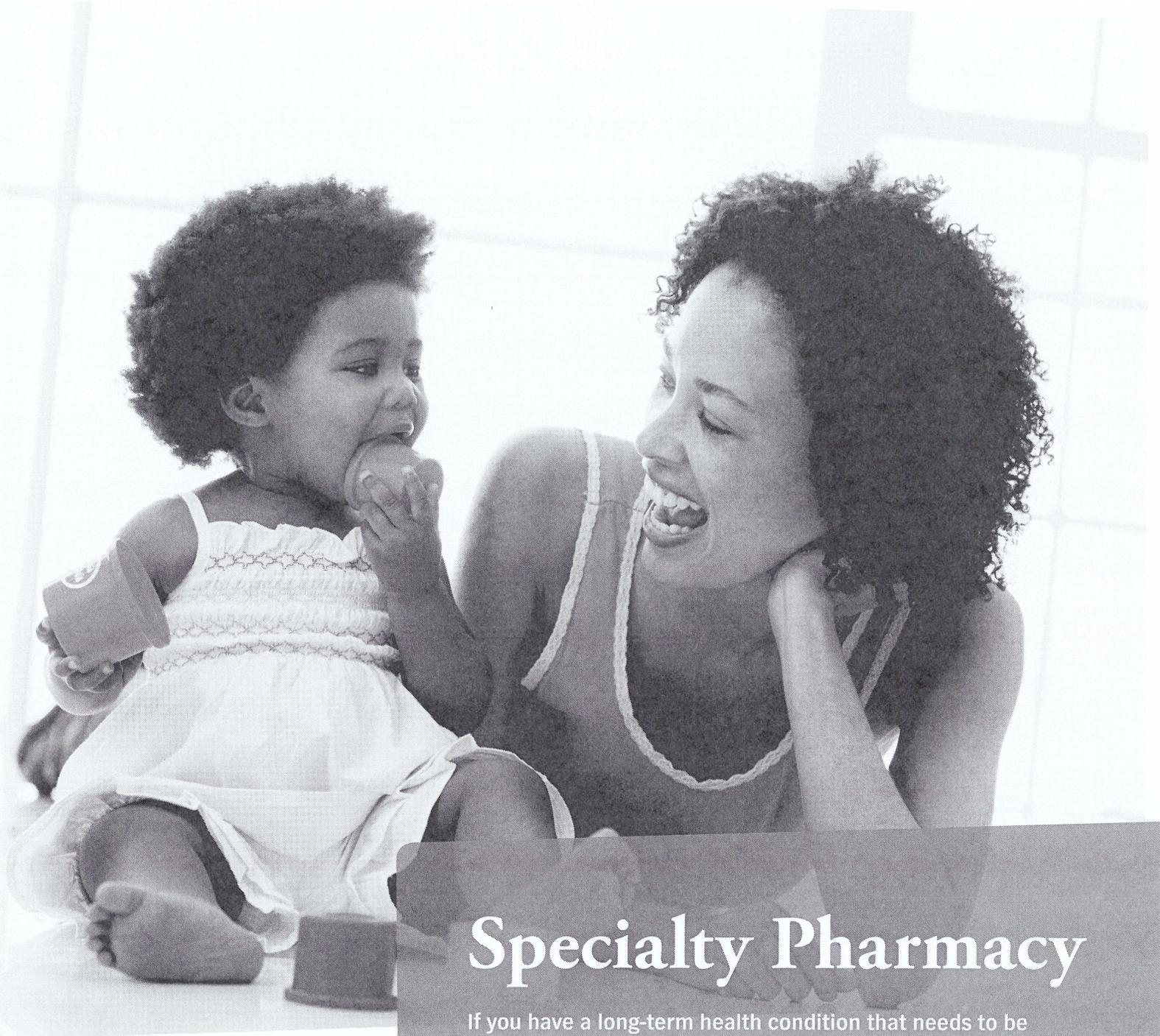
## Need help getting started?

Call the phone number on your ID card. You will be transferred to Express Scripts. They can help you get started.

\*Based on drug benefit plan design.

anthem.com

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# Specialty Pharmacy

If you have a long-term health condition that needs to be treated with complex drugs, our specialty pharmacy is here for you. You'll get the medicine you need and support to manage your condition.



## What is a specialty pharmacy?

A specialty pharmacy provides medicine for people with long-term health conditions. Specialty drugs come in different forms like pills or liquids. And some need to be injected, infused or inhaled. These drugs often need special storage and handling and may be given to you by a doctor or nurse.

The specialty pharmacy is for people with conditions that include:

- Asthma
- Bleeding disorders
- Cancer
- Crohn's disease
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Iron overload
- Living with a transplant
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)

## Your specialty pharmacy team.

You don't have to manage your health condition alone. Our team of experts is here to help you get the best results from your treatments.

- Pharmacists can explain your condition, how your drugs work and possible side effects. They can also answer urgent drug questions after hours.
- Nurses help you stay on track with your medicine. They make sure you're taking it just how the doctor prescribes. They can also help you deal with your side effects.
- Plus, the pharmacy has a team that can answer questions about insurance, paying for your medicine, refilling drugs and much more.

## The Specialty Pharmacy drug list

Log on to [anthem.com](http://anthem.com) to view/download the Specialty Pharmacy drug list.

<sup>1</sup>To better understand your specialty pharmacy drug coverage, please see your Summary of Benefits or call the phone number on your member ID card.

### A note about your pharmacy information on the web:

The first time you're sent to the Express Scripts website you'll go through a brief registration to set your preferences for email and privacy. You'll do this only once.

Please do not go directly to the Express Scripts website. The only way to make sure you're viewing your pharmacy information correctly is by logging in to [anthem.com](http://anthem.com) first.

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## Getting started with the specialty pharmacy.

Our specialty pharmacy is Accredo, which is part of Express Scripts. Express Scripts is the company that manages and processes drugs for your health plan.<sup>1</sup>

Your plan may require you to use Accredo. Other plans let you choose from a list of specialty pharmacies, including Accredo. You can visit [anthem.com](http://anthem.com) or call the phone number on your member ID card to be sure.

You can easily switch to Accredo with a simple phone call or fax. A care representative will work with you and your doctor and start the arrangements to move your specialty prescriptions.

**Call: 800-870-6419**, Monday through Friday, 8 a.m. to 11 p.m., Eastern time and Saturday, 8 a.m. to 5 p.m., Eastern time.

**Fax: 800-824-2642**. Ask your doctor to fax your prescription(s) and a copy of your member ID card.

A care representative will call you back to arrange for delivery of your medication on a day that is convenient for you.

Accredo and the specialty pharmacy network apply to drugs covered under the pharmacy benefit only.

## Ordering refills.

Once you're ready to refill your medicine, you can place your order online or on the phone.

**Online:** Visit [anthem.com](http://anthem.com).

- Log in and under Useful Tools, click **Prescription Benefits** then click Order a Refill. You will be sent to the Express Scripts website.
- Choose the drugs you want to refill and click **Add Refillsto Cart**.
- Review the order, shipping method, payment and other details. Make changes if needed.
- **Click Place My Order**.

**By phone:** Have your member ID card and prescription number ready. Call 800-870-6419 and choose "Place a Refill Order" from the menu. Or press zero any time to speak with someone. If you are speech or hearing impaired, call 800-955-8770 (TTD/TTY). Follow the prompts to place your order.



## 24/7 NurseLine Always here for you

Health concerns can happen when you least expect them. You might be on vacation or even on a business trip. Or your child may have a fever in the middle of the night. But there's somewhere you can turn for help any time of the day or night.

Call the **24/7 NurseLine** to talk with a registered nurse about your health concern. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. And, if you want, a nurse will call you later to see how you're doing.

Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do. Do you need to head straight to the emergency room? Is urgent care best? Or do you need to see your doctor? Making the right call can save you time and money – and give you access to the best possible care.

Do you speak Spanish or another language other than English? We have Spanish-speaking nurses and translators on call. TTY/TDD services are available, too.

If you'd prefer not to talk about your health concern over the phone, the AudioHealth Library might be for you. These helpful prerecorded messages cover more than 300 health topics in English and Spanish. Just call the 24/7 NurseLine number and choose the AudioHealth Library option.



### Health questions?

**24/7 NurseLine is always here for you.  
Call toll free at 866-647-6120.**

**85% of members like you would recommend  
24/7 NurseLine to others.**



# LiveHealth Online<sup>®</sup>

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Talk to a doctor today, tonight, anytime — 365 days a year. Just enroll at [livehealthonline.com](http://livehealthonline.com) or on the free mobile app.



## Now you can get the health care you need without all the hassle

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.\*

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at a cost of only \$20/visit under the PPO or \$49/visit under the HDHP; subject to deductible and coinsurance.
- Private, secure and convenient online visits.

### What are the qualifications of the doctors you consult via LiveHealth Online?

- U.S. board-certified.
- Average 15 years practicing medicine.
- Mostly primary care physicians.
- Specially trained for online visits.

### When can you use LiveHealth Online?

As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

### Start a conversation now.

Just enroll for free at [livehealthonline.com](http://livehealthonline.com) or on the app, and you're ready to see a doctor.

## Download the app now!

[apple.com](http://apple.com)



[play.google.com/store](http://play.google.com/store)



\*As legally permitted in certain states.

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# Live life to the fullest – without paying full price



## SpecialOffers@Anthem<sup>SM</sup> on anthem.com

### Save money with discounts at anthem.com

Saving money is good. Saving money on things that are good for you – that's even better. With SpecialOffers@Anthem<sup>SM</sup>, you can get discounts on products and services that help promote better health and well-being.\* It's just one of the perks of being a member. Check out how much you can save:

#### Vision and hearing

**1-800 CONTACTS<sup>®</sup>** – Get contact lenses quick and easy – plus discounts only available to Anthem members, like \$20 off when you spend \$100 or more and free shipping.

**Glasses.com<sup>™</sup>** – Get the latest, brand-name frames for just a fraction of the cost at typical retailers – every day. Plus, you get an additional \$20 off orders of \$100 or more, free shipping and free returns.

**Premier LASIK** – Save 15% on LASIK with all in-network providers. Prices are as low as \$695 per eye with select providers.

**Amplifon** – Get a low-price guarantee with the seven top companies that work with Amplifon. Save \$50 on one hearing aid or \$125 on two. Plus, get a three-year repair/loss/damage warranty and a free two-year supply of batteries.

**Beltone<sup>™</sup>** – Get hearing screenings and in-home service at no additional cost, and up to 50% off all Beltone hearing aids.

#### Fitness and health

**Jenny Craig<sup>®</sup>** – Join Jenny Craig and get a 30-day trial at no additional cost and 50% off enrollment.

**Lindora<sup>®</sup>** – Save 20% on weight-loss programs.

**SelfHelpWorks** – Choose one of the online Living programs and get a 40% discount to help you lose weight, stop smoking, manage stress or face an alcohol problem.

**GlobalFit<sup>™</sup>** – Save on gym memberships, home fitness equipment and GlobalFit's Virtual Gym.

**ChooseHealthy<sup>™</sup>** – Get preferred pricing on fitness club memberships and a one-week free trial. Enjoy discounts on acupuncture, chiropractors and massage – plus 40% off certain wellness products.

**Performance Bicycle** – Get \$20 off a purchase of \$80 or more in store or online.



# SpecialOffers@Anthem<sup>SM</sup> on anthem.com

## Family and home

**Safe Beginnings<sup>®</sup>** — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

**VPI Pet Insurance** — Get 5% off pet insurance. Get peace of mind knowing that you have help paying the medical costs for your pet's accidents, illnesses and routine medical care.

**ASPCA Pet Health Insurance** — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

**LinkWell** — Get coupons for healthier products.

**WINFertility<sup>®</sup>** — Save up to 40% on infertility treatment. WINFertility helps make quality treatment affordable.

**LifeMart<sup>®</sup>** — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

## Medicine and treatment

**Puritan's Pride** — Save 10% and get free shipping on a large selection of vitamins, minerals, herbs, supplements and much more.

**Murad<sup>®</sup>** — Save \$25 and get a free gift with any purchase of \$100 or more on skin care products.

**Allergy Control products** — Save 25% on Allergy Control encasings for your bed. Plus, save 20% on a variety of doctor-recommended products for a healthier home and enjoy free shipping on orders of \$150 or more.

**National Allergy<sup>®</sup> supply** — Save 15% on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms.

To find the discounts that are available to you, log in to [anthem.com](http://anthem.com) and select **Discounts**.



\* All discounts are subject to change without notice.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

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# Nine months. Many questions.

Future Moms can help –  
any time, any day

Having a healthy baby is every mom's goal. And it starts with a healthy pregnancy. You want to make the right choices and take care of yourself so you can reach that goal. But it's not always easy to do it alone.

That's why there's Future Moms. It's a program that can answer your questions, help you make good choices and follow your health care provider's plan of care. And it can help you have a safe delivery and a healthy child.

Sign up as soon as you know you're pregnant. Just call us toll free at **866-647-6120**. One of our registered nurses will help you get started. You'll get:

- A toll-free number you can use to talk to a nurse coach any time, any day, about your pregnancy. A nurse may also call you from time to time to see how you're doing.
- A book that shows changes you can expect for you and your baby during the next nine months.
- A screening to check your health risk for depression or early delivery.
- Other useful tools to help you, your doctor and your Future Moms nurse keep track of your pregnancy and help you make healthier choices.
- Free phone calls with pharmacists, nutritionists and other specialists, if needed.
- A booklet with tips to help keep you and your new baby safe and well.
- Other helpful information on labor and delivery, including options and how to prepare.



## It's easy to join

Sign up for Future Moms by calling us toll free at **866-647-6120**. There's no extra cost to you.



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MWISH1311A Rev. 06/14



## ComplexCare: *Support when you need it the most*

Coping with a health problem that needs extra care can be stressful. If you have many complex health issues, it can be confusing and scary.

Fortunately, our nurses in the **ComplexCare program** are experts in helping you deal with your condition — or conditions. They can work closely with you and your doctors to create a customized plan. Our goal is to help you improve your health and your quality of life.

If you qualify for the ComplexCare program, one of our nurses may call you.

As a ComplexCare member you will get:

- Personal attention to help you set — and achieve — healthy lifestyle goals.
- Answers to questions about your treatments.
- New ideas to help you care for yourself and stick with your doctor's advice.
- Referrals to other 360° Health® programs that may help you.
- Help coordinating care between your doctors and other providers.

Our nurses are backed by a team of specialists in pharmacy, nutrition and other areas. ComplexCare nurses will have the latest data on your treatment options.

**It's comforting to know that ComplexCare is here when you need it most and at no additional cost.**

### What ComplexCare members say:

- 87% would recommend the program.\*
- Over two-thirds learned more about their health and improved their diet.\*



\*Source: 2010 Membership Satisfaction Studies

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MANSH3152A Rev. 11/11 F0023836

*If you're trying to quit smoking,*  
**Why go it alone?**

**Now you've got more support than ever — and it comes at no extra cost!**

Under health care reform, you can get certain FDA-approved prescription drugs and many over-the-counter (OTC) products to help you quit smoking and it won't cost you anything extra!

**It's all part of the preventive care benefit that comes with health care reform. Here's how it works:** To get certain prescriptions and nicotine replacement products covered in full (no cost to you), here's all you have to do:

- 1. Ask your doctor** if one or more of the covered prescription drugs and/or OTC products (listed on the next page) would be good for you. If so, you'll need to get a prescription for each one. (Yes, even certain OTC products to help you quit smoking will need a prescription in order to be covered at no cost to you.)
- 2. Go to a pharmacy** that's in your health plan's network to fill your prescription. You can check [anthem.com](http://anthem.com) to find a network pharmacy.
- 3. Show the pharmacist proof that you're at least 18** years of age. If you're under 18, you may need to speak with your doctor or other health care professional to get your OTC product, because by law, they can only be sold to people who are over 18.

**Once you quit, better health begins — in minutes!**

You'll literally get healthier 20 minutes after you quit smoking because your heart rate and blood pressure will go down. In the months to follow, your circulation will improve and your chances of getting heart disease, stroke and cancer will drop significantly, too.<sup>1</sup>

**Ready to call it quits?**

See the next page for a list of FDA-approved prescription drugs and OTC products that you can get at no cost. If you have any questions, call the phone number listed on your member ID card.



<sup>1</sup> The American Cancer Society website, *When Smokers Quit - What are the Benefits Over Time* cancer.org, October 4, 2012.

**Prescription drugs and over-the-counter (OTC) products that are fully covered as part of the health care reform law:\***

**Prescription drugs**

- Chantix
- Buproban
- Bupropion SR (generic Zyban)

**OTC Nicotine Replacement Therapy (NRT) products**

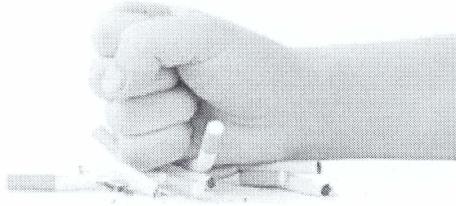
Type of NRT	Brand-name and generic products that are covered at 100% <sup>6</sup>
<b>Nicotine gum</b> Available in 2mg and 4mg doses	CVS nicotine chewing gum EQ nicotine chewing gum GNP nicotine chewing gum HM nicotine chewing gum LDR nicotine chewing gum Nicorelief nicotine chewing gum PC nicotine chewing gum Pub Stop Smoking aid 2mg and 4mg gum PV nicotine chewing gum Quit 2 nicotine chewing gum Quit 4 nicotine chewing gum RA nicotine chewing gum SM nicotine chewing gum SW nicotine chewing gum Thrive nicotine chewing gum Please note: Nicorette is not covered.
<b>Nicotine lozenge</b> Available in 2mg and 4mg doses	CVS nicotine lozenge EQL nicotine lozenge GNP nicotine lozenge HM nicotine lozenge Nicorelief nicotine lozenge Pub Stop Smoking aid 2mg and 4mg lozenge RA nicotine lozenge SM nicotine lozenge SW nicotine lozenge Please note: Commit is not covered.
<b>Nicotine transdermal patch</b> (also called a nicotine skin patch) Available in single daily doses of 7mg, 14mg, or 21mg	CVS nicotine transdermal patch EQ nicotine transdermal patch EQL nicotine transdermal patch HM nicotine transdermal patch PV nicotine transdermal patch RA nicotine transdermal patch SM nicotine transdermal patch Please note: Habitrol and Nicoderm are not covered.

\*Some drugs are subject to a quantity limit review before they are covered.

**Get even more support at [anthem.com](http://anthem.com)!**

Log on and click on our Health and Wellness section for resources, videos and even an online community for information and inspiration to help you quit!

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



## **SMOKE NO MORE...**

Did you know tobacco cessation counseling and treatment programs when used in conjunction with prescription and over-the-counter medications to help you quit smoking can significantly increase your chances for success?

Smoking cessation counseling and other tobacco use treatment programs are covered to a maximum benefit of \$500 per lifetime.

For information on this program, visit the Intranet or contact Human Resources, Monday – Friday, 8 am to 5 pm.

**Wisconsin Tobacco QuitLine, 1-800-QUIT-NOW (800-784-8669), 7 am – 2 am daily.**

\*The City reserves the right to modify, suspend, or cancel this program at any time.

### **Did you know...**

The Employee Assistance Program offers Behavioral Change Coaching, FREE personal one-on-one coaching to assist you with kicking the habit. Contact Aurora EAP, 800-236-3231 to schedule your appointment.

# DENTAL INSURANCE

- **Standard Dental Plan** – Administered by Anthem, 877-567-1805, [www.anthem.com](http://www.anthem.com)

**OR**

- **CarePlus Prepaid Dental Plan** – Administered by Dental Associates, Ltd., 414-771-1711, [www.dentalassociates.com](http://www.dentalassociates.com)

A. **You must enroll** in a dental plan option listed above to have dental coverage in effect for plan year beginning March 1, 2016.

- Complete the enclosed *Care-Plus Dental Enrollment* form to enroll in the Care-Plus Prepaid Dental Plan, OR the *Health and/or Standard Dental Application* form (same form as the health enrollment) to enroll in the Standard Dental Plan.
- Employees who maintain coverage for dependents (spouse and/or child[ren]) and/or who intend to add dependents (spouse and/or child[ren]) to their dental insurance are required to determine coverage eligibility (refer to dependent definition which may found after the Dental Comparison chart). Proper documentation (e.g., marriage/birth/adoption certificate) must be provided for qualified spouse/dependents being added to the plan who did not have coverage immediately prior to this enrollment period.

B. Return your enrollment form to the Human Resources Department on or before **5:00 p.m., Wednesday, February 10, 2016; YOUR FORM MUST BE RECEIVED EVEN IF YOU CHOOSE TO DECLINE COVERAGE.** (If you are declining dental coverage, please mark the applicable boxes as listed on the top of the *Health and/or Standard Dental Application* form.) Information on the dental plans is available on the City's website at [www.westalliswi.gov/openenrollment](http://www.westalliswi.gov/openenrollment), or from Human Resources, City Hall, Monday - Friday, 8:00 a.m. - 5:00 p.m., 414-302-8270.

**NOTE: Domestic partners are not eligible for dental insurance coverage.**

MONTHLY PREMIUM EFFECTIVE 3-1-16		
Plan Type	Standard Plan	Care Plus
Single (Employee Only)	\$ 37.00	\$ 34.58
Family (Employee plus 1 or more)	\$102.00	\$106.38

The City continues to offer dental insurance coverage at no monthly cost for regular, full-time employees. Regular part-time employees, holding a minimum of 0.5 FTE (full-time equivalent) budgeted position, continue to be prorated based on FTE; contact the Finance Department for your monthly rate calculation.

**DENTAL INSURANCE PROGRAM COMPARISON - CITY OF WEST ALLIS**

	<b>CARE-PLUS PREPAID</b>	<b>STANDARD<sup>2</sup> PLAN</b>
<b>MAXIMUM COVERAGE</b> Per person per plan year	\$1,500	\$1,500
<b>DEDUCTIBLE</b> Per person per plan year Family maximum	None	\$ 75 \$225
<b>DIAGNOSTIC</b> Examination and necessary x-rays	No Charge to Maximum	100%* (not subject to deductible)
<b>PREVENTIVE</b> Prophylaxis (cleaning), fluoride treatment, preventive training, space maintainers	No Charge to Maximum	100%* (not subject to deductible)
<b>RESTORATIVE</b> Amalgam and composite fillings, porcelain to metal crowns	No Charge to Maximum	80% to Maximum
<b>PROSTHETICS</b> Full and partial dentures, fixed bridges, repairs and additions	No Charge to Maximum	50% to Maximum
<b>ENDODONTICS</b> Pulpal therapy, root canals, apicoectomy	No Charge to Maximum	80% to Maximum
<b>ORAL SURGERY<sup>1</sup></b> Simple extractions	No Charge to Maximum	80% to Maximum
<b>PERIODONTICS<sup>1</sup></b> Treatment for diseases of gums and tissue of the mouth	No Charge to Maximum	80% to Maximum
<b>DEPENDENT ELIGIBILITY</b>	Covered through the end of the month turn 26 – refer to backside for full details.	Covered through the end of the month turn 26 – refer to backside for full details.
<b>ORTHODONTICS</b> (lifetime maximum benefit) To age 19	Patient pays first \$500	Anthem pays 50% of first \$2,400 (not subject to deductible; benefit is in addition to the \$1500 max. coverage benefit noted above)
<b>Example</b> \$3,400 Case	You Pay \$500 <sup>3</sup>	You Pay \$2,200

<sup>1</sup>Does not duplicate medical coverage.

<sup>2</sup>Usual and Customary charge applies for all services in Standard Plan.

<sup>3</sup>Convenient payment plan available.

\*SUBJECT TO YEARLY MAXIMUM

## DEPENDENT COVERAGE:

**Dependent** means a covered **employee's**:

1. Legally recognized spouse;
2. Natural blood related child, step-child, legally adopted child or a child under **your** legal guardianship as determined with a court decree whose age is less than the limiting age. Each child must legally qualify as a **dependent** as defined by the United States Internal Revenue Service guidelines or applicable State Statutes.

**Limiting age and eligibility criteria:**

### Dependent children under age 26 (as required by federal and state mandates):

The limiting age for each **dependent** child is the end of the month he or she attains the age of 26 years, regardless if the child is:

- a. Married;
- b. A tax dependent;
- c. A student;
- d. Employed;
- e. Residing with or receives financial support from *you*; or
- f. Eligible for other coverage through employment.

### Dependent child, age 26 and older (as required by State mandate), who is called to federal active duty:

The limiting age is any age for each **dependent** child age 26 and older when they meet the requirements outlined below. **Dependent** termination is the end of the month they no longer meet these requirements.

- The child is a full-time student; and
  - The child was 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 an institution of higher education on a full-time basis; and
  - The child was under age 27 when called to federal active duty; and
  - The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; and
  - If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.
3. A covered **employee's** child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
  4. Grandchild, as long as the **employee's** covered **dependent**, who is the parent of the grandchild, is not yet age 18.

**You** must furnish satisfactory proof to the **City** upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

A covered **dependent** child who attains the limiting age while covered under the Plan will remain eligible for medical benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a **dependent** as determined by the United States Internal Revenue Service;
4. Unmarried.

**You** must furnish satisfactory proof to the **City** that the above conditions continuously exist on and after the date the limiting age is reached. The **City** may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

## STANDARD DENTAL PLAN HAS ADDED BENEFIT

The Standard Dental Plan (administered by Anthem) has a Passive Dental PPO program. You and your spouse/eligible dependents have the ability to obtain dental care needs from *any dentist*. However, you will share in the discounts negotiated by Anthem if you seek care from a dentist participating in the *Anthem Dental Complete* network. The end result is lower out-of-pocket expenses and enhanced annual maximums for each covered member selecting a participating dentist. (The negotiated fee schedule under which the participating *Anthem Dental Complete* network dentist is contracted results in a discount in excess of 20%.)

### Sample Savings Calculation

Example: Code 2140 Amalgam – One Surface/Basic – Savings of \$1.00

	Participating (fee schedule)	Non-Participating (UCR)
Fee Schedule	\$129.00	\$134.00
Coinsurance	20%	20%
Member's Responsibility	\$26.00	\$27.00

Example: Code 5110 Complete Denture - maxillary/Major – Savings of \$44.00

	Participating (fee schedule)	Non-Participating (UCR)
Fee Schedule	\$1,489.00	\$1,578.00
Coinsurance	50%	50%
Member's Responsibility	\$745.00	\$789.00

Please call Anthem at 877-567-1805 or visit Anthem's website at [www.Anthem.com](http://www.Anthem.com) to obtain the most up-to-date listing of participating dentists.

## **SECTION 125 FLEXIBLE SPENDING: DEPENDENT CARE REIMBURSEMENT**

A Section 125 Flexible Spending Account (FSA) for Dependent Care Reimbursement allows an employee to have dollars deducted from their paycheck on a pre-tax basis to pay for work-related dependent care expenses. Eligible expenses include those that would otherwise qualify for the Federal Dependent Care Tax Credit, such as childcare, day care centers, after-school care and adult dependent care. The program is administered by Employee Benefits Corporation (EBC), 800-346-2126; [www.ebcflex.com](http://www.ebcflex.com) or [www.participantservices@ebcflex.com](mailto:www.participantservices@ebcflex.com).

1. Employees wishing to enroll or re-enroll in the Dependent Care Reimbursement program **MUST** complete a new enrollment form and return to the Finance Department **NO LATER THAN 5:00 p.m. Wednesday, February 10, 2016.**
2. No action is necessary if you wish to discontinue your current allotments for dependent care reimbursement.
3. You may participate in the plan even if you are not enrolled in the City's health or dental insurance plans.
4. The plan year runs from March 1, 2016 through February 28, 2017, with an additional 2-1/2 month grace period to spend and submit claims (through May 15, 2017). Any eligible dependent care expenses you incur during the grace period between March 1, 2017 through May 15, 2017, would be eligible to be reimbursed from your 2016 account as well as from your 2017 account, *if* you re-enroll in the program in 2017. In other words, the grace period provides "overlapping coverage." Funds that are not used in a timely manner are forfeited.

The Dependent Care Reimbursement annual limit is \$5,000 for qualifying individuals and those who are married and file a joint return (or \$2,500 if married and file separate returns).

### **\*IMPORTANT\***

**Employee Benefits Corporation strongly recommends employees have their dependent care reimbursements deposited directly into a personal savings or checking account; this can be accomplished by completing EBC's *Authorization for Direct Deposit* form included in your Open Enrollment packet. If you do not choose this option, it is your responsibility to notify EBC in the event you have a change in address; failure to do so may result in a \$25 forfeiture for each returned check.**

## **HOW DOES A FLEXIBLE SPENDING ACCOUNT (FSA) FOR DEPENDENT CARE REIMBURSEMENT WORK?**

An employee decides on a dollar amount (\$5,000 maximum contribution for qualifying individuals and those who are married and file a joint return; \$2,500 per employee if married filing separately) they want to contribute to a Dependent Care FSA based on estimated out-of-pocket expenses for the upcoming Plan year. The election amount (which is divided over 26 pay periods in the Plan year) is deducted pretax from each paycheck and held in a Dependent Care FSA. After the employee and/or eligible spouse/dependent(s) incur(s) an eligible expense, a claim is submitted by the employee to the City's Section 125 third party administrator for processing; claims may be submitted via smartphone, fax, US Mail, or online. The employee will be sent a reimbursement check for the incurred expenses. The check is paid from the employee's Dependent Care FSA. **FUNDS NOT USED WITHIN THE PLAN YEAR ARE FORFEITED**

## **WHAT ARE THE ADVANTAGES OF AN FSA FOR DEPENDENT CARE REIMBURSEMENT?**

An FSA for Dependent Care Reimbursement allows you to increase your take-home pay by reducing your taxable income. Wages used in your Dependent Care FSA are not subject to federal, state or social security tax. As a direct result of the personal tax savings, you will actually increase your spendable income by changing the payment of your expenses from an after-tax to a pre-tax basis. Generally this could mean a potential tax savings of up to 30% on expenses you are already paying for. (Actual tax savings depends on your tax bracket.)

## **CAN I CHANGE MY ELECTION AT ANY TIME?**

No; your election amount will remain in effect for the plan year. Changes in elections may only be made if you experience a qualified change in status. The IRS defines a qualified change in status to include:

- Change in your legal marital status
- Change in the number of your tax dependents
- Your dependent satisfies (or ceases to satisfy) eligibility requirements such as reaching the age limit or getting married
- Change in residence for you or your spouse or dependent that affects eligibility of your benefits
- Change in employment for you or your spouse or dependent that affects eligibility of your benefits

Questions or concerns regarding Section 125: Flexible Benefits may be directed to Employee Benefits Corporation (EBC), 800-346-2126, or [www.ebcflex.com](http://www.ebcflex.com), or [www.participantservices@ebcflex.com](mailto:www.participantservices@ebcflex.com), or the City's Finance Department at 414-302-8260.

# DEFERRED COMPENSATION

Section 457 Deferred Compensation is a voluntary tax-deferred savings plan. Through this plan, you are permitted to save money on a pre-tax basis. These savings are not subject to federal or state income tax. Advantages of this plan over other savings programs include:

- Your employer administers the Deferred Compensation plan.
- Contributions are automatically deducted from your salary each pay period on a pre-tax basis.
- You reduce your current income taxes while investing for retirement.
- Your earnings accumulate tax-deferred.
- The Plan enables you to increase your savings without significantly reducing your take home pay.
- You can increase, decrease, stop and restart contributions as often as you wish.

**The City offers several plans, ICMA-RC, Wisconsin Deferred Compensation Program, and MetLife, from which to choose investment options.** These plans have several different alternatives in which to invest. They are at different levels of risk – low, medium and high. It is the employee's choice as to which plan, or plans, to invest. The City does not give advice on which company or plan to choose and is not responsible for employee gains or losses that result from such decisions.

## What is Deferred Compensation?

Simply stated, Deferred Compensation is an IRS approved method for deferring federal and state income taxes on savings until retirement. Taxes are paid on the savings and earnings when withdrawn, usually during retirement when the employee is presumably in a lower income tax bracket.

## Who is Deferred Compensation for?

Generally, any employee may participate in the plan. Individuals in the following categories *should* consider participating in the plan:

1. Individuals who are paying comparatively high levels of income tax.
2. Individuals who are currently saving on an after-tax basis.
3. Families with dual incomes.
4. Single individuals with no dependents.
5. Individuals approaching retirement.
6. Individuals who currently have adequate emergency funds.

## How is the Deferred Compensation Plan regulated?

Deferred Compensation was established by Section 457 of the IRS tax code to enable public employees to defer federal income taxes on a portion of their savings. Employers retain ownership of your tax deferred savings until you are eligible to receive benefits.

## **What happens to the money I elect to defer?**

When you enroll in the plan, you request that your withheld compensation be placed in one or more of the available investment options. An account is established into which your Deferred Compensation amounts are placed, and to which all investment earnings are credited.

You will receive quarterly reports showing how much you have deferred, in which option(s) it was invested, the amount of your investment earnings, and the total current value of your account.

## **How much salary can be deferred?**

The contribution limit for 2016 is 100% of compensation to a maximum of \$18,000 annually. If you will become 50 years of age (or older) in 2016, you may contribute up to an additional \$6,000 to Deferred Compensation, for a total of \$24,000. The "Catch-up" provision provides individuals that are near retirement the ability to contribute an additional \$18,000, for a total of \$36,000. Contact your Retirement Plan Specialist for details on this provision.

You have the flexibility to increase, decrease, stop and restart contributions as often as you wish, without fees or penalties.

## **How does the amount I defer affect my income tax return?**

Your taxable income is reduced by the amount of money that you choose to defer. For example, if your salary is \$26,000 and you defer \$2,600, your taxable gross income is shown as \$23,400 on your W-2 Form, and no entry need be made on your income tax return.

## **When can I receive my money deferred under the plan?**

Your Deferred Compensation is payable to you upon one of these five events:

1. Termination of Employment
2. Retirement
3. Disability
4. Death
5. Severe Financial Hardship – with required approvals

For more information contact Human Resources at 414-302-8270 or a Deferred Compensation representative (refer to the 2016 Deferred Compensation Schedule).

## **CITY SPONSORS 457 LOAN PROGRAM THROUGH ICMA**

The City of West Allis sponsors a Section 457 Deferred Compensation Loan feature through ICMA Retirement Corporation that provides eligible plan participants the ability to borrow funds from their plan account balance, for any purpose. The minimum loan amount is \$1,000 and the maximum shall not exceed \$50,000. Participants may receive one loan per calendar year, but may have only one outstanding loan at a time. Loans for active employees must be repaid through payroll deduction. For more information, contact the City's Finance Department at 414-302-8260.

## 2016 DEFERRED COMPENSATION SCHEDULE

ICMA, MetLife, and Wisconsin Deferred Compensation Program (WDC) representatives will be at the following locations from 11:30 a.m. – 1:30 p.m. for individual meetings on the dates listed below.

### **Tyge Olson**

Retirement Plans Specialist  
ICMA-RC  
777 North Capitol St., NE  
Washington, DC 20002  
W: 866-328-4677 #4 or  
262-377-7270  
E: [tolson@icmarc.org](mailto:tolson@icmarc.org)

### **Keith Olson and Pete Voss**

Financial Services Representative  
MetLife  
Great Lakes Agency  
9000 West Chester St., Suite 100  
Milwaukee, WI 53214  
414-541-4490  
E: [kolson1@metlife.com](mailto:kolson1@metlife.com)

### **Joseph Herron**

Wisconsin Deferred Compensation Program (WDC)  
5325 Wall Street, Suite 2755  
Madison, WI 53718  
W: 877-457-WDCP (9327)  
Cell: 262-902-7817  
E: [joseph.herron@greatwest.com](mailto:joseph.herron@greatwest.com)

February 9	Fire Administration
March 8	Police Department
April 12	Department of Public Works
May 10	Library
June 14	Fire Administration
July 12	Police Department
August 9	City Hall Council Chambers/Clerk's Conference Room/Purchasing Conference Room
September 13	Fire Administration
October 11	Department of Public Works
November 8	Police Department
December 13	Library



# LIFE INSURANCE

The City provides a Basic Life Insurance policy to qualified\* individuals with coverage in the amount of your annual salary adjusted to the next highest one thousand dollars. Individuals are also eligible for additional options to expand this Basic coverage. The first option allows you to insure up to four more times the Basic policy. The second option allows you to purchase Spouse and Dependent coverage. Both options are paid through employee payroll deductions. Employees who did not enroll in life insurance during their initial enrollment period, or employees who wish to apply for more insurance for themselves and/or their spouse/dependents, may apply through Evidence of Insurability. Employees are also allowed the opportunity to enroll or add a level of life insurance coverage and Spouse/Dependent coverage, without Evidence of Insurability, after a qualifying family status change event. Further information and forms may be obtained from the Intranet or Human Resources, 414-302-8270.

Claims experience for local government employees insured under the Wisconsin Public Employers Group Life Insurance program has been stable. Therefore, effective July 1, 2016, **there will be no change** in employee rates for Basic, Supplemental, and Additional coverage. Spouse and Dependent premium rates will also remain at their current levels.

### WISCONSIN PUBLIC EMPLOYER GROUP LIFE PLAN Monthly Rates Per \$1,000 of Insurance *Basic, Supplemental, and Additional Insurance*

Attained Age	Effective 7-1-15	Effective 7-1-16
Under 30	\$.05	\$.05
30-34	.06	.06
35-39	.07	.07
40-44	.08	.08
45-49	.12	.12
50-54	.22	.22
55-59	.39	.39
60-64	.49	.49
65-69**	.57	.57
70 and over	***	***

### Monthly Premium Rates *Spouse/Dependent*

1 Unit (\$10k spouse/\$5k per child)	\$1.75
2 Units (\$20k spouse/\$10k per child)	\$3.50

\*The Life Insurance Program is administered in accordance with plan guidelines of the State of Wisconsin, Department of Employee Trust Funds, 877-533-5020.

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

\*\*\*When an active employee reaches age 70:

- Basic coverage continues at a reduced level without further premiums
- Supplemental and Additional coverages cease
- The employee may apply for Additional Age 70 and Older coverage



## EMPLOYEE ASSISTANCE PROGRAM

The City recognizes that concerns of a personal nature can have an adverse effect on an employee's job performance. It also recognizes that most personal problems can be dealt with successfully when identified early and referred to appropriate resources.

The Employee Assistance Program is available to help employees who develop emotional or physical problems. Most conditions can be successfully treated. All information is confidential and will not jeopardize job security or promotional opportunities.

The Employee Assistance Program also offers comprehensive Work-Life services that can make life a little easier for you and your family. In today's fast-paced, demanding world, balancing home and job responsibilities can be overwhelming. Work-Life services are designed to solve problems and help you handle life changes and challenges more effectively, without taking valuable time and energy away from your job. Work-Life services include:

- Child Care Consultation, Information, and Referral
- Elder Care Consultation, Information, and Referral
- Legal Consultation
- Mediation Services
- Adoption Information Service
- Financial Consultation
- Legal and Financial Resource Center

Behavioral Change Coaching modules are also offered by the Employee Assistance Program. You can receive free one-on-one coaching in key areas such as Tobacco Cessation, Marijuana Use, Alcohol Abuse, Coping with Stress, Anxiety & Change, Communication/Conflict Resolution, and Anger Management.

You have unlimited access to website resources on legal and financial issues, including forms, financial tools, and a complete library of in-depth articles and information from experts in the field. Go to the Aurora EAP web site [www.Aurora.org/eap](http://www.Aurora.org/eap). Log in as an employee using password *westallis* to access a variety of resources.

Help begins with a phone call. Simply call the Aurora Employee Assistance Program at 800-236-3231 and talk to one of their intake professionals. They will connect you with a specialist who can provide prompt, personalized assistance. They'll help you resolve your concern and restore a healthy balance to your life – at work and at home.



*Aurora Health Care*®

**Employee Assistance Program**

**800-236-3231**

**[www.aurora.org/eap](http://www.aurora.org/eap)**



# **REQUIRED NOTIFICATIONS**





# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 1-31-2017)

## PART A: General Information

When key parts of the health care law took 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 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 tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the immediately following January 1.

### 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.<sup>1</sup>

**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 Anthem, (844) 286-6371

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

<sup>1</sup> 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.

3. Employer name City of West Allis		4. Employer Identification Number (EIN) 39-6005651	
5. Employer address 7525 W. Greenfield Ave.		6. Employer phone number 414-302-8270	
7. City West Allis	8. State WI	9. ZIP code 53214	
10. Who can we contact about employee health coverage at this job? Human Resources Department			
11. Phone number (if different from above) (same)		12. Email address akey@westalliswi.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:

Employees holding a minimum of 0.5 FTE (full time equivalent) budgeted position, and Elected Officials.

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Refer to last page of document for complete dependent definition.

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](http://HealthCare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](http://HealthCare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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. End of plan year is February 28, 2017; changes unknown thereafter.

**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

\* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

## DEPENDENT COVERAGE:

**Dependent** means a covered **employee's**:

1. Legally recognized spouse;
2. Natural blood related child, step-child, legally adopted child or a child under **your** legal guardianship as determined with a court decree whose age is less than the limiting age. Each child must legally qualify as a **dependent** as defined by the United States Internal Revenue Service guidelines or applicable State Statutes.

**Limiting age and eligibility criteria:**

### Dependent children under age 26 (as required by federal and state mandates):

The limiting age for each **dependent** child is the end of the month he or she attains the age of 26 years, regardless if the child is:

- a. Married;
- b. A tax dependent;
- c. A student;
- d. Employed;
- e. Residing with or receives financial support from *you*; or
- f. Eligible for other coverage through employment.

### Dependent child, age 26 and older (as required by State mandate), who is called to federal active duty:

The limiting age is any age for each **dependent** child age 26 and older when they meet the requirements outlined below.

**Dependent** termination is the end of the month they no longer meet these requirements.

- The child is a full-time student; and
- The child was 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 an institution of higher education on a full-time basis; and
- The child was under age 27 when called to federal active duty; and
- The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; and
- If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.

3. A covered **employee's** child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
4. Grandchild, as long as the **employee's** covered **dependent**, who is the parent of the grandchild, is not yet age 18.

**You** must furnish satisfactory proof to the **City** upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

A covered **dependent** child who attains the limiting age while covered under the Plan will remain eligible for medical benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a **dependent** as determined by the United States Internal Revenue Service;
4. Unmarried.

**You** must furnish satisfactory proof to the **City** that the above conditions continuously exist on and after the date the limiting age is reached. The **City** may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

## **NOTICE OF EXEMPTIONS PER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of benefit and enrollment requirements. However, federal law permits local government employers that sponsor self-funded health plans to elect to exempt a plan from some of these requirements. Therefore, the City of West Allis has elected to be exempt from the following requirements:

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 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 takes a medically necessary leave of absence from a postsecondary educational institution.

Presently, the City of West Allis Plans voluntarily provide similar protections to those set forth in requirement 3 above. The City of West Allis Plans are not subject to any minimum or maximum hospital stays in connection with the birth of a child. Such determinations are made by the individual's health care provider.

The exemption from these federal requirements is being renewed and implemented for the term of the January 1, 2012 through December 31, 2014 Collective Bargaining Agreement and will remain in effect until the ratification and adoption of a successor to that Agreement. The exemption may be renewed for subsequent years as determined by the term of such Collective Bargaining Agreements within the City.

Any questions regarding this Notice may be directed to Audrey Key, Human Resources Director, City of West Allis, at 414-302-8274.

Rev 1-2016

# City of West Allis Notice of Privacy Practices

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

### PLEASE REVIEW THIS DOCUMENT CAREFULLY

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We understand the importance of keeping your health information private. Personal health information (PHI) includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by federal and state law to maintain the privacy of your health information. This is a notice of the City of West Allis' privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices as described in this Notice while it is in effect. This Notice takes effect on April 14, 2003 and will remain in effect until amended or rescinded.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permissible by law. We reserve the right to make the changes in our privacy practices and the new terms of this Notice effective for all health information that we maintain, including health information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this Notice and make the new Notice available. For more information about our privacy practices, or for additional copies of this Notice, please contact us at the number listed at the end of this Notice.

Our policy is to:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information without your consent/authorization, in the following ways:

**Treatment:** Your health information may be disclosed to a doctor, a hospital or other entity that asks for it in order for you to receive medical treatment.

**Payment:** Your health information may be used or disclosed to pay, or obtain payment for, claims for covered services provided to you by doctors, hospitals, other entities or the City of West Allis. A bill may be sent to Medicare or your insurance provider with accompanying documentation that identifies you, your diagnosis, and the treatment provided to you.

**Health Care Operations:** Your health information may be used or disclosed for the following reasons:

- To determine premiums for the health plan.
- To assess the care you received and the outcome of your case compared to others like it.
- In an effort to continually improve the quality and effectiveness of the care and services provided to you, your information may be reviewed for provider performance evaluation, risk management, training or quality improvement purposes.
- For premium rating, ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance).
- To conduct or arrange for medical review, legal services and audit functions, including fraud and abuse detection, and compliance programs.
- For business planning, such as conducting cost-management and planning-related analysis, including formulary development and administration, or improvement of methods of payment or coverage policies.

**Plan Sponsors:** Your health information may be disclosed to the plan sponsor for plan administration activities. Please see your plan documents for a full explanation of the limited uses and disclosures that the plan sponsor may make of your personal and health information in providing plan administration functions for your group health plan.

**Business Associates:** There are some services provided in the City through contracts with business associates. Examples include health insurance consulting services provided by an insurance broker, services provided to administer the self-insured health plans and services provided by a billing company to pursue payment for health care rendered. When these services are contracted, your health information may be disclosed to the business associates so they can perform their jobs under the contract.

**Underwriting:** Your health information may be used for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. This health information will not be used or further disclosed for any other purpose, except as required by law, unless you become a Plan member. At that time, the use and disclosure of your health information will only be as described in this Notice. Genetic information may not be used or disclosed for underwriting purposes.

**Family and Friends:** If you are unavailable to communicate, such as in a medical emergency or disaster relief, your health information may be disclosed to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

**Death:** The health information of a deceased person may be disclosed to a coroner, medical examiner or funeral director.

**Public Health and Safety:** Your health information may be disclosed, to the extent necessary, to avert a serious and imminent threat to your health or safety or the health or safety of others. Your health information may be disclosed to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

**Required by Law:** Your health information must be used or disclosed when required to do so by law.

**Process and Proceedings:** Your health information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process.

**Military, National Security, or Incarceration/Law Enforcement Custody:** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, your health information may be disclosed to the proper authorities so they may carry out their duties under the law.

**Worker's Compensation:** Your health information may be disclosed to the appropriate person in order to comply with the laws related to Worker's Compensation or other similar programs.

**Appointment Reminders:** Your health information may be used or disclosed to provide you with appointment reminders such as voicemail messages, postcards, letters, etc.

#### **AUTHORIZING USE AND DISCLOSURE OF HEALTH INFORMATION**

Written authorization will be requested from you whenever there is a need to use your health information or to disclose it to anyone for any purpose or situation not included in this document. Most uses and disclosures of psychotherapy notes and any disclosure of PHI for marketing or for which a health plan receives compensation require written authorization. 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. We will not use or disclose your health information for any reason except those described in this Notice without your written authorization.

#### **HEALTH INFORMATION RIGHTS**

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact the City of West Allis Human Resources Department ("Contact Office") using the contact information at the end of this Notice. Specifically, you have the right to:

**Access:** With few exceptions, you have the right to review and/or obtain copies of your health information. Requests must be made in writing. If you request copies, we may charge you a reasonable fee for each page and for staff time to locate and copy your health information and, if mailed, we may charge for postage.

**Disclosure Accounting:** You have a right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities. Effective April 14, 2003, we will begin maintaining these types of disclosures for up to six (6) years. 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 the additional requests.

**Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. Except as noted below, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in a need for your emergency treatment. We will comply with any restriction request if the disclosure is to a health plan (or the health plan's business associate) for purposes of payment or health care operations (not for treatment), if the disclosure is not otherwise required by law, and the health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. You also have the right to agree to or terminate a previously submitted restriction.

**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, we do not maintain the information, or the information is accurate and complete.

**Alternative 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 to avoid a life-threatening situation. You must make the request in writing and you must state that the information could endanger you if it is not communicated in confidence. Your request must identify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you requested. Your request will be accommodated if it is reasonable.

**Breach Notification:** You have the right to be notified in the event we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with Federal requirements.

**Intranet Posting of Notice:** In addition to the paper copy of this Notice, this Notice is available electronically through the City of West Allis Intranet, HR Document Library, HR Forms folder.

#### **COMPLAINTS**

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, you may file a complaint with us using the contact information listed at the end of this Notice.

You may also 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 OFFICE AND INFORMATION**

If you want more information about our privacy practices or have questions or concerns regarding your privacy rights, please contact us as follows:

**Contact Office:** City of West Allis Human Resources Department  
**Telephone:** 414-302-8270  
**Fax:** 414-302-8275  
**Email:** akey@westalliswi.gov  
**Address:** 7525 West Greenfield Avenue, West Allis, WI 53214

Rev 1-2016

# CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

## Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage through the City of West Allis but are unable to afford the premiums, Wisconsin may have premium assistance programs that can help pay for coverage. The State uses funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you/they live in Wisconsin, you can contact Wisconsin's Medicaid or CHIP office at 800-362-3002 or online at <http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm> to find out if premium assistance is available.

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](http://www.healthcare.gov).

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 Wisconsin's Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://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.

Upon determination that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the City's health plan is required, under two circumstances, to permit you and your dependents to enroll in the plan, as long as you and your dependents are eligible and *not already enrolled* in the City's plan:

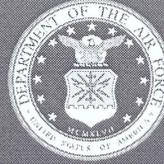
1. When the employee or dependent covered under Medicaid or CHIP has coverage terminated as a result of loss of eligibility, and the employee requests coverage under the group health plan; or
2. When the employee or dependent becomes eligible for premium assistance (i.e., becomes subsidy-eligible) under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium

This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. Contact the State for further information and eligibility 800-362-3002 or <http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>.

For more information on special enrollment rights:

U.S. Department of Labor  
Employee Benefits Security Admin.  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
866-444-EBSA (3272)

U.S. Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
877-267-2323, Menu Option 4, Ext. 61565



# YOUR RIGHTS UNDER USERRA THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

**USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.**

## REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

## RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

## HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

## ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at **<http://www.dol.gov/elaws/userra.htm>**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



**U.S. Department of Labor  
1-866-487-2365**

**U.S. Department of Justice Office of Special Counsel**

**1-800-336-4590**

Publication Date—October 2008

## FAMILY AND MEDICAL LEAVE (FMLA)

The City of West Allis complies with the Wisconsin and federal Family and Medical Leave Acts. Employees are eligible under Wisconsin FMLA if they have worked for the City at least 52 consecutive weeks and for at least 1,000 hours during that 52-week period, and under federal, if the employee has been employed by the City for at least 12 months (not necessarily consecutive) and has worked at least 1,250 hours during the 12 months prior to the start of the FMLA leave. Employees may qualify for Family or Medical Leave for any one or more of the following reasons:

- The birth or placement of a child for adoption or, under the federal FMLA, for foster care or a child of a person standing in loco parentis.
- To care for the employee's spouse, child, or parent with a serious health condition. The Wisconsin FMLA includes caring for a spouse's parent, domestic partner and a domestic partner's parent. The federal FMLA includes standing "in loco parentis" to a child.
- The employee's own serious health condition that renders the employee unable to perform his/her job.
- Under the federal FMLA, if the employee experiences a qualifying exigency that arises out of the fact that a spouse, parent, or child in the armed forces (including members of the National Guard or Military Reserves) has been deployed or called to covered active military duty in a foreign country.
- Military Caregiver Leave – An eligible employee who is the spouse, parent, child, or next of kin of a current member of the armed forces/covered service member (including the regular armed forces, the National Guard and the Reserves), or a veteran who served in the military within the preceding 5 years and whose discharge was not dishonorable, who was injured while on active duty, or whose pre-existing injury or illness was aggravated by service on active duty, may be eligible for up to 26 workweeks of federal FMLA leave in a single 12-month period to care for the service member/veteran who is undergoing medical treatment, recuperation, or therapy for a serious service-related injury or illness, or a service-related aggravation of a pre-existing injury or illness, incurred while in the line of duty. Leave to care for an injured or ill service member/veteran, when combined with other FMLA-qualifying leave, may not exceed 26 workweeks in a single 12-month period.

Details regarding provisions of these Acts are posted at worksites. For further information contact the Human Resources Department and/or refer to the City's Family and Medical Leave Act Policy, #1448. The City's Policy and related Forms may be found in the Human Resources document library of the Intranet.

## EXTERNAL REVIEW/APPEALS PROCESS

Federal health care reform (HCR) requires non-grandfathered group health plans to provide an external claims review/appeals process. When your insurance plan denies payment for medical treatment or services after considering your (internal) appeals, the law permits you, under certain circumstances, to have an independent review organization decide whether to uphold or overturn your health plan's decision. This final step is often referred to as an "external review". All applicable internal appeals processes must be exhausted prior to allowing the request for an external appeal.

Questions regarding internal appeals and external review provisions can be directed to Anthem at 844-286-6371. You may also find information at the U.S. Department of Health and Human Services website, [www.healthcare.gov](http://www.healthcare.gov).

## **FORM 1095C**

Effective for tax year 2015, the IRS requires employers to issue a Form 1095-C for any active employees not enrolled in Medicare, who participated in the City's Health Insurance Program for one or more months during the 2015 calendar year. You will be required to provide the form when filing your 2015 income tax as proof of employer-sponsored coverage. The City's Finance Department is the reporting agent for the IRS; if you believe you received a form in error or that you should have received one, please contact Finance at 414-302-8262.

## **W-2 REPORTING**

Federal health care reform (HCR) requires employers to report the value of employer-sponsored health care coverage on employee W-2s. This reporting requirement is informational only and does not create additional taxable income. In other words, employees will not be taxed on the value of this coverage as part of their regular earnings. The purpose of the reporting is to provide useful and comparable consumer information to employees on the cost of their health care. The costs reported will include both the employer and employee contributions based on the level of coverage elected (single, couple, or family).

## **UNIFORM SUMMARY OF BENEFITS AND COVERAGE (SBC) AND GLOSSARY OF TERMS**

Federal health care reform (HCR) mandates employers to provide a uniform Summary of Benefits and Coverage (SBC) and a Glossary of Health Coverage and Medical Terms (both are available on the Intranet or from Human Resources). The SBC and Glossary summarize important information about the City's health plan options in a standard format per federal HCR, in an attempt to help you understand your benefits. Anthem and Willis Towers Watson (City's health insurance consultant) recommend members utilize the City's Health Benefit Summaries located in this booklet versus the standardized documents that will be made available by Anthem, and address any questions/concerns to Anthem at 844-286-6371.

## **NO ANNUAL/LIFETIME LIMITS**

Federal health care reform (HCR) prohibits health plans from putting an annual or lifetime dollar limit on benefits you receive. There is no annual or lifetime in-network and out-of-network limit on the dollar value of benefits under the City of West Allis' health plans.

## **MANDATORY REPORTING OF SOCIAL SECURITY NUMBERS**

Under the Medicare, Medicaid, and CHIP, the City is required to report the social security numbers of all employees, spouses and dependents participating in our health insurance. Social Security numbers are reported to Medicare so that a determination can be made of which plan is to pay primary when dual coverage exists with Medicare. Penalties are imposed on the employer for non-compliance.

Revised 1-2016

## COBRA GENERAL NOTICE

Under Federal law, commonly referred to as COBRA, if your group health benefits or those of a dependent, spouse or child end due to a “qualifying event”, you may elect coverage under the plan provided you are not: (a) entitled to Medicare or (b) covered under another group plan.<sup>1</sup> You and/or your dependents have the right to elect coverage under the plan for up to 18, 29 or 36 months depending on the qualifying event.

In order to continue coverage, election must be made within 60 days after: (a) the date you are notified of your continuation right, or (b) the date the insurance would end, whichever is later. If there is any coverage elected, the initial payment for it must be made within 45 days of the election. All other premiums are payable on a monthly basis and given a 31 day grace period. If payments are not received within the grace period, coverage will terminate and may not be reinstated. If any statements for premiums are received after coverage expires for any reason, they should be ignored. Continued billing is not to be considered an extension of coverage. After the initial payment, you must submit the monthly payment, until you have been advised of a general change for all participants. The monthly premium may not change more often than once in any designated plan 12 month period, unless there is a change in premium for all persons covered due to a change in benefits provided under the plan.

You have the responsibility to notify your Employer within 60 days of the following qualifying events: a divorce or legal separation; or, a child ceasing to be eligible under the terms of the plan. If this is not done, coverage will not be provided.

The continued coverage will end on the earliest of the following:

- 18 months after the date of termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the employee ineligible for coverage (however, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the first day of the first qualifying event); or
- 36 months after the date of any other qualifying event;
- the date the employer ceases to provide any group health plan to any employee;
- the date the employee or eligible dependent fails to make any required premium payment when due;
- the first day after the date of election on which the employee or eligible dependent is covered under any other group health plan; or
- the date the employee or eligible dependent is entitled to Medicare.

A special provision applies to a person who is totally disabled for Social Security purposes on the date of the qualifying event. The 18 month period may be extended to 29 months. In order for this additional 11 months of coverage to be effective, the employee or eligible dependent must provide the employer notice of the determination within 60 days of the Social Security determination of total disability, and within the initial 18 months of COBRA continuation coverage.

<sup>1</sup> There may be other coverage options for you and your family other than COBRA, such as the Health Insurance Marketplace ([www.healthcare.gov](http://www.healthcare.gov)) or coverage under another group health plan for which you are eligible (such as a spouse's plan). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

Another special provision applies in a situation in which a covered employee has a qualifying event (termination or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event. In this case, any other qualified beneficiary (the spouse and/or children) would be entitled to the greater of

- (i) 36 months of COBRA from the date the employee first became entitled to Medicare or
- (ii) 18 months of COBRA from the covered employee's termination or reduction in hours.

If your COBRA coverage expires due to the expiration of the maximum time period, you may be eligible for a conversion policy that may contain different coverage provisions.

#### **ADDENDUM TO COBRA CONTINUATION RULES:**

Effective January 1, 1997, the Health Insurance Portability and Accountability Act of 1996 made the following changes to the COBRA continuation rules:

1. The extension for disability will be available to any qualified beneficiary who is disabled in the first 60 days after continuation coverage begins. The Social Security Administration (SSA) must make the determination of disability within the first 18 months of continuation coverage, and the disabled beneficiary must give the health plan's administrator notice in writing of the SSA's determination within 60 days of the determination before the extended period of coverage will be available. (Remember, to preserve your right to additional coverage by reason of disability, you must inform the City of West Allis-Human Resources Department of the determination of disability within 60 days of the date it was made.)
2. A newborn infant of or child placed for adoption with the covered employee is entitled to receive COBRA continuation coverage as a qualified beneficiary having independent COBRA rights. (Remember, you must inform the City of West Allis-Human Resources Department that you have a newborn infant or a child under age 18 who has been placed with you for adoption in order that they may be added to your COBRA coverage. The group health plan has a special enrollment period for newborn infants and adopted children [as well as for any other dependents acquired through marriage]. This period lasts for 30 days, beginning on the date the child is born or placed for adoption. To enroll the child, you must obtain an enrollment form from the City of West Allis-Human Resources Department, complete the form, and submit it within this 30 day period. If you do not do so, you will not be able to enroll the new dependent until the plan's next regular enrollment period.)

Treating a newborn infant or adopted child as a qualified beneficiary is important if, during the first 18 months of continuation coverage following the covered employee's termination of employment or reduction in hours, there is a second qualifying event - death of the covered employee, divorce or legal separation of the employee from his or her spouse, the employee becoming entitled to Medicare, or the dependent child ceasing to be a "dependent" under the group health plan - that allows a qualified COBRA beneficiary to elect an additional 36 months of coverage. A qualified beneficiary also has the same right to receive certain COBRA notifications as you have.

A child is considered as "placed for adoption" when the adoptive parent assumes and retains the legal obligation for the total or partial support of the child, meaning that an order to this effect has been issued by a proper court or other agency having authority to do so.

## FOR MORE INFORMATION

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description. You can get a copy of your summary plan description from the City of West Allis Human Resources Department.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 866-444-3272. There may be other more affordable health insurance options for you and your family other than COBRA, such as the Health Insurance Marketplace; visit [www.healthcare.gov](http://www.healthcare.gov) or call 800-318-2596 for more information.

### **Keep Your Plan Informed of Address Changes**

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

The City of West Allis is an Equal Opportunity/Affirmative Action Employer and does not discriminate against individuals on the basis of race, color, religion, age, marital or veterans' status, sex, national origin, disability, or any other legally protected status in the admission or access to, or treatment or employment in, its services, programs or activities.

Upon reasonable notice the City will furnish appropriate auxiliary aids and services when necessary to afford individuals with disabilities an equal opportunity to participate in and to enjoy the benefits of a service, program or activity provided by the City.

It is the policy of the City of West Allis to provide language access services to populations of persons with Limited English Proficiency (LEP) who are eligible to be served or likely to be directly affected by our programs. Such services will be focused on providing meaningful access to our programs, services and/or benefits.