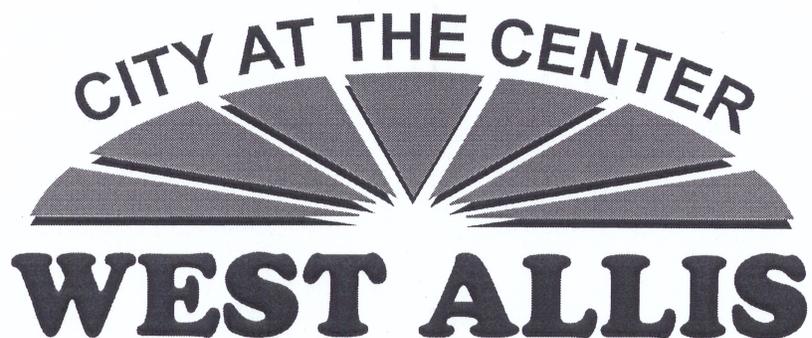


**2016**  
**RETIREE HEALTH INSURANCE**  
**OPEN ENROLLMENT**

**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 ( <i>Doctor’s Only</i> ): 800-824-2642	<a href="http://www.anthem.com">www.anthem.com</a>
<b>ETF (WRS Pension/Life Insurance)</b>	877-533-5020	<a href="http://www.etf.wi.gov">www.etf.wi.gov</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 retiree's responsibility to notify Human Resources within 30 days of a qualifying event\* (e.g., death of a spouse, re-marriage of deceased retiree's spouse, divorce, legal separation, Medicare/Medicaid/Title 19 eligibility, attaining Medicare age, dependent no longer qualifies for health coverage) to make a change to health insurance coverage. When a change is communicated to Human Resources, such information is forwarded to our third party administrators and to our Finance Department for processing. The change may or may not affect your monthly insurance premiums.

\*Must provide proof of qualifying event where applicable (e.g., marriage/birth certificate or divorce decree, Medicare/Medicaid/Title 19 enrollment card).

## 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 ETF's website, [etf.wi.gov](http://etf.wi.gov). You can also call them toll-free at 877-533-5020 or 608-266-3285 (local Madison). Forms are also available from Human Resources, 414-302-8270.



# HEALTH INSURANCE

Administered by Anthem, 844-286-6371, [www.anthem.com](http://www.anthem.com)

For plan year 3-1-16 to 2-28-17, the City is offering two (2) plan options: (1) continuation of its PPO Plan, and (2) implementation of a High Deductible Health Plan (HDHP).

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.

## Enrollment Procedures

- ✓ Every retiree is required to return an application form *even if* you choose not to participate in the City's Retiree Health Insurance Program plan offerings for this plan year effective March 1. (If you are declining health coverage, you will need to complete a *Waiver of Coverage* form available on the City's website at [www.westalliswi.gov/openenrollment](http://www.westalliswi.gov/openenrollment) or from Human Resources.)
- ✓ The application form must be submitted to the Human Resources Department by **5:00 p.m., Wednesday, February 10, 2016**. Application forms received after the close of Open Enrollment may result in monetary penalties and/or cancellation of coverage.
- ✓ Retirees who maintain coverage for dependents (spouse and/or child[ren]) and/or who intend to add dependents (spouse and/or child[ren]) to health insurance are subject to the insurance provisions in place at the time of retirement. Retirees are required to determine coverage eligibility for dependents (refer to the dependent definition found on the last page of the Health Benefit Summaries). Proper documentation (e.g., marriage/birth/adoption certificate) must be provided for qualifying dependents being added to the plan who did not have coverage immediately prior to this enrollment period.

This Open Enrollment informational guide, 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.**



# PPO PLAN

This plan is similar to the City's current Humana PPO Plan, the difference being the provider network and third party administrator (Anthem vs. Humana).

## Points of interest:

- ✓ Medical and prescription drug benefit levels remain dependent upon date of retirement.
- ✓ Provider network options are dependent upon primary residence and date of retirement.
- ✓ This plan qualifies as a Medicare Part D Creditable Plan.
- ✓ Prescription drugs may fall under different copay tiers (amount you pay for drugs) than what you are used to paying under Humana.

Pharmacy Provider (Members will be required to obtain all new prescriptions for mail order and specialty pharmacy prescriptions):

- 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.

Health Care Providers (provider verification directions included within this guide):

### Retired BEFORE 3-1-2013:

- If your primary residence is located within Anthem's *Blue Priority* service area (see map):
  - In-Network: select "*Blue Priority*" network to verify provider participation; when traveling outside of Wisconsin, select "*National PPO (Blue Card PPO)*".
  - Out of Network: any non- "*Blue Priority*" or "*National PPO (Blue Card PPO)*" provider.
- If your primary residence is in Wisconsin but located outside of Anthem's *Blue Priority* service area (see map):
  - In-Network: select "*Blue Preferred*" network to verify provider participation; when traveling outside of Wisconsin, select "*National PPO (Blue Card PPO)*".
  - Out of Network: any non- "*Blue Preferred*" or "*National PPO (Blue Card PPO)*" provider.
- If your primary residence is outside of Wisconsin:
  - In-Network: select "*National PPO (Blue Card PPO)*" network to verify provider participation.
  - Out of Network: any non- "*National PPO (Blue Card PPO)*" provider.

### Retired ON OR AFTER 3-1-13:

- If your primary residence is located anywhere in Wisconsin:
  - In-Network: when seeking care in the *Blue Priority* service area (see 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 (Blue Card PPO)*" network to verify provider participation;
  - Out-of-Network: any non- "*Blue Priority*" or "*National PPO (Blue Card PPO)*" provider.
- If your primary residence is located outside of Wisconsin:
  - In-Network: when seeking care, select "*National PPO (Blue Card PPO)*" to verify provider participation;
  - Out-of-Network: any non- "*National PPO (Blue Card PPO)*" provider.





## PPO PLAN BENEFIT SUMMARY FOR INDIVIDUALS WHO RETIRED PRIOR TO 3-1-13

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.

- **If your primary residence is located within Anthem's *Blue Priority* service area (see map):**
  - In-Network: select "*Blue Priority*" network to verify provider participation; when traveling outside of Wisconsin, select "*National PPO (Blue Card PPO)*".
  - Out of Network: any non- "*Blue Priority*" or "*National PPO (Blue Card PPO)*" provider.
  
- **If your primary residence is in Wisconsin but located outside of Anthem's *Blue Priority* service area (see map):**
  - In-Network: select "*Blue Preferred*" network to verify provider participation; when traveling outside of Wisconsin, select "*National PPO (Blue Card PPO)*".
  - Out of Network: any non- "*Blue Preferred*" or "*National PPO (Blue Card PPO)*" provider.
  
- **If your primary residence is outside of Wisconsin:**
  - In-Network: select "*National PPO (Blue Card PPO)*" to verify provider participation.
  - Out of Network: any non- "*National PPO (Blue Card PPO)*" provider.

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
<b>MAXIMUM COVERAGE</b>	No dollar limit.	\$1,000,000 annually if retired prior to 3-1-12; \$1,250,000 annually if retired 3-1-12 to 2-28-13.
<b>DEDUCTIBLES</b>	No deductible.	Unless otherwise noted, across the board deductibles of \$200 per person or \$600 per family per Plan year.
<b>PERCENT OF COVERED CHARGES (COINSURANCE)</b>	100% of eligible charges after applicable copays.	Unless otherwise noted, the Plan pays 70% of the reasonable & customary charges for medically necessary/eligible services after the deductible has been satisfied.  Local 80 (PW & Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alders prior to 4-15-08; other retirees prior to 3-1-07: the Plan pays 80% of reasonable & customary charges for medically necessary/eligible services after deductible has been satisfied, unless otherwise noted.
<b>ANNUAL OUT-OF-POCKET LIMIT ON EXPENSES</b>	No dollar limit.	Maximum out-of-pocket coinsurance (including the deductible) is \$1,500 per person or \$3,000 per family per Plan year; thereafter, the Plan pays 100% of reasonable & customary charges for medically necessary/eligible services.
<b>AMBULANCE</b>	100% of eligible charges when medically necessary.	Same as in network services.
<b>URGENT CARE FACILITY</b>	100% of eligible charges if billed as "urgent care" visit; member subject to office visit copay if billed as "office visit"; member subject to ER copay if billed as "emergency visit".	Same as in network services.

	<b>IN NETWORK SERVICES</b>	<b>OUT OF NETWORK SERVICES</b>
<b>EMERGENCY CARE</b>	100% of eligible charges if admitted inpatient, doctor directed or transported by emergency vehicle; otherwise \$25 copay. <i>(Note: individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-28-12 are also subject to this benefit level.)</i> <b>(Applies to retiree groups not listed in categories on next page.)</b>	Same as in network services.
<b>EMERGENCY CARE (Continued)</b>	100% of eligible charges if written directive from doctor, admitted inpatient, or transported by emergency vehicle; otherwise \$75 copay for Non-Reps/Dept Hds/City Atty/Judge who retired 3-1-07 to 2-28-10; Police (WAPPA)/Fire (IAFF) unions who retired 3-1-07 to 2-28-09; Nurses/Engineering unions who retired 3-1-07 to 2-28-11; and Mayor/Alderspersons who retired 4-15-08 to 2-28-10. <b>(Applies to retiree groups 42, 46, &amp; 48.)</b>  100% of eligible charges ONLY IF admitted inpatient or transported by emergency vehicle; otherwise \$75 copay for Police (WAPPA)/Fire (IAFF) unions who retired 3-1-09 to 2-28-13; Non-Reps/Dept Hds/Elected Officials who retired 3-1-10 to 2-28-13; Nurses/Engineering unions who retired 3-1-11 to 12-31-11; individuals converted to Non-Rep status (former Nurses and Engineering union members) who retired 1-1-12 to 2-28-13, and (former AFSCME union members) who retired 3-1-12 to 2-28-13. <b>(Applies to retiree groups 47, 49, 52, 53, 55, 57, 58 &amp; 59.)</b>	Same as in network services.
<b>ROUTINE PHYSICALS &amp; HEALTH CHECKUPS</b>	100% of eligible charges. Subject to office visit copay (as listed under Physician Office Visits).	Not covered.
<b>IMMUNIZATIONS &amp; INJECTIONS</b>	100% of eligible charges.	Not covered.
<b>X-RAY &amp; LAB TESTS</b>	100% of eligible charges.	70% of reasonable & customary charges, with prior authorization.  Local 80 (PW & Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable & customary charges, with prior authorization.
<b>EYE EXAMS</b>	100% of eligible charges (routine vision care limited to one visit per Plan year). Subject to office visit copay (as listed under Physician Office Visits).	Not covered.
<b>ALLERGY CARE</b>	100% of eligible charges. Subject to office visit copay (as listed under Physician Office Visits).	70% of reasonable & customary charges.  Local 80 (PW & Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable & customary charges.

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
HEARING EXAMS	100% of eligible charges. Subject to office visit copay (as listed under Physician Office Visits).	Not covered.
PHYSICIAN OFFICE VISITS	<p>100% of eligible charges except as noted below.</p> <p>\$10 office visit co-pay with capitation at five (5) visits per person per Plan year for Local 80 (PW &amp; Clerical) retirees 3-1-04 to 12-31-11, individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-28-12; Police (WAPPA) 12-1-03 to 2-28-07; Fire (IAFF) 1-1-04 to 2-28-07; Nurses 8-1-04 to 2-28-07; Engineers 1-1-04 to 2-28-07; Non Reps/Dept Hds/City Atty/Judge 3-1-04 to 2-28-07; Mayor/Alderspersons 3-1-04 to 4-14-08. <b>(Applies to retiree groups 20, 21, 24, 45, &amp; 50.)</b></p> <p>\$20 office visit copay with max. of \$200 single/\$400 couple/\$600 family for Non-Reps/ Dept Hds/Police (WAPPA)/Fire (IAFF)/City Atty/Judge who retired 3-1-07 to 2-28-09; Nurses/Engineering unions 3-1-07 to 2-28-11; and Mayor/Alderspersons 4-15-08 to 2-28-09. <b>(Applies to retiree groups 42 &amp; 46.)</b></p> <p>\$20 office visit copay with NO maximum Plan year out-of pocket. Co-pay waived for wellness/routine/preventative services for Police (WAPPA)/Fire (IAFF)/Non-Reps/Dept Hds/Elected Officials who retired on or after 3-1-09; Nurses/Engineering unions who retired 3-1-11 to 12-31-11; individuals converted to Non-Rep status (former Nurses/Engineering union members) who retired on or after 1-1-12; and individuals converted to Non-Rep status (former AFSCME union members) who retired on or after 3-1-12. <b>(Applies to retiree groups 47, 48, 49, 52, 53, 55, 57, 58, &amp; 59.)</b></p>	<p>70% of reasonable &amp; customary charges.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges.</p>
PHYSICIAN VISITS IN HOSPITAL	100% of eligible charges.	<p>70% of reasonable &amp; customary charges, with prior authorization.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges, with prior authorization.</p>
DURABLE MEDICAL EQUIPMENT	100% of eligible charges for initial purchase or rental when authorized; does not cover repair or replacement.	<p>70% of reasonable &amp; customary charges for initial purchase or rental when authorized; does not cover repair or replacement.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable/customary charges for initial purchase/rental when authorized; does not cover repair or replacement.</p>

	<b>IN NETWORK SERVICES</b>	<b>OUT OF NETWORK SERVICES</b>
<b>PODIATRY SERVICES PROVIDED BY A PODIATRIST</b>	<p><b>SUBJECT TO OUT-OF-NETWORK BENEFIT LEVELS. (Applies to retiree groups 2, 8, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 24, 42, 47, 53, &amp; 59.)</b></p> <p>Non-Reps/Dept Hds/Elected Officials/ Local 80 (PW &amp; Clerical) who retired on or after 4-1-08; Nurses who retired on or after 7-1-08; Engineers who retired on or after 8-1-08; Police (WAPPA) union who retired on or after 3-1-12; and individuals converted to Non-Rep status (former AFSCME, Nurses, Engineering union members who retired on or after 1-1-12). Subject to office visit copay (as listed under Physician Office Visits).</p>	<p>70% of reasonable &amp; customary for non-routine care only.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderpersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary for non-routine care only.</p>
<b>MATERNITY</b>	<p>Hospital &amp; physician charges covered at 100% of eligible charges; dependent daughters covered.</p>	<p>70% of reasonable &amp; customary charges, with prior authorization.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderpersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges, with prior authorization.</p>
<b>PEDIATRIC CARE</b>	<p>100% of eligible charges. Subject to office visit copay (as listed under Physician Office Visits).</p>	<p>70% of reasonable &amp; customary charges.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderpersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges.</p>
<b>SHORT TERM PHYSICAL THERAPY</b>	<p>100% of eligible charges as long as it is deemed medically necessary (provider must be able to document improvement in the condition as a review will be required after 15 visits).</p> <p>NOTE: Subject to an office visit copay (as listed under Physician Office Visits) if provider bills as an office visit; if billed as a physical therapy appointment, no copay.</p>	<p>70% of reasonable &amp; customary charges.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderpersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges.</p>
<b>CHIROPRACTIC CARE</b>	<p>100% of eligible charges. (Provider must be able to document improvement in condition after 15 visits). Subject to office visit copay (as listed under Physician Office Visits).</p>	<p>70% of reasonable &amp; customary charges.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderpersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges.</p>
<b>RADIATION THERAPY</b>	<p>100% of eligible charges.</p>	<p>70% of reasonable &amp; customary charges, with prior authorization.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderpersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable &amp; customary charges, with prior authorization.</p>

	<b>IN NETWORK SERVICES</b>	<b>OUT OF NETWORK SERVICES</b>
<b>ALCOHOLISM/ DRUG ABUSE</b>	Included in psychiatric and mental health benefits.	Included in psychiatric and mental health benefits.
<b>OUTPATIENT MENTAL HEALTH SERVICES</b>	100% of eligible charges. Subject to office visit copay (as listed under Physician Office Visits).	90% of reasonable & customary charges; not subject to deductible.  <u>TRANSITIONAL CARE</u> - 90% of reasonable & customary charges; not subject to deductible.
<b>INPATIENT PSYCHIATRIC CARE</b>	100% of eligible charges.	90% of reasonable & customary charges, with prior authorization; not subject to deductible.
<b>HOSPITALIZATION</b>	100% of eligible charges.	70% of reasonable & customary charges, with prior authorization.  Local 80 (PW & Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable & customary charges, with prior authorization.
<b>SURGICAL CARE OR SURGERY</b>	100% of eligible charges.	70% of reasonable & customary charges, with prior authorization.  Local 80 (PW & Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of reasonable & customary charges, with prior authorization.
<b>ORAL SURGERY</b>	100% of eligible charges for initial treatment for injury to sound, natural teeth & for specific diseases, including removal of full bony symptomatic impacted wisdom teeth. Prior authorization required.	70% of eligible charges for initial treatment for injury to sound natural teeth and for specific diseases, including removal of full bony symptomatic impacted wisdom teeth. Prior authorization required.  Local 80 (PW & Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of eligible charges for initial treatment for injury to sound natural teeth and for specific diseases, including removal of full bony symptomatic impacted wisdom teeth. Prior authorization required.
<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.	

PRESCRIPTION DRUGS	IN NETWORK SERVICES Retail: Express Scripts (nationwide network) Mail Order: Express Scripts	OUT OF NETWORK SERVICES																																	
	<p>Cost per prescription or refill; up to 34-day retail supply and 90-day mail order supply (includes insulin and diabetic supplies).</p> <p>All who retired prior to 3-1-03; OR 1-1-03 for Fire (IAFF) union; OR 12-1-03 for Police (WAPPA) union; OR 8-1-04 for Nurses union. <b>(Applies to retiree groups 2, 8, 10, 11, 12, 13, 15, &amp; 16):</b></p> <table border="1" data-bbox="462 558 906 646"> <thead> <tr> <th></th> <th>Retail</th> <th>Mail Order</th> </tr> </thead> <tbody> <tr> <td>Generic</td> <td>\$3</td> <td>\$0</td> </tr> <tr> <td>Brand</td> <td>\$5</td> <td>\$3</td> </tr> </tbody> </table> <p>Police (WAPPA)/Fire (IAFF)/Nurses/Engineering unions who retired 3-1-07 to 2-28-09; Non-Reps/Dept Hds/City Atty/Judge who retired 3-1-07 to 2-28-13 and individuals converted to Non-Rep status (former AFSCME, Nurses &amp; Engineering union members) who retired 3-1-12 to 2-28-13 ; Mayor/Alderspersons who retired 4-15-08 to 2-28-13. <b>(Applies to retiree groups 42, 46, 48, 49, 55, &amp; 58):</b></p> <table border="1" data-bbox="397 993 964 1218"> <thead> <tr> <th></th> <th>Retail</th> <th>Mail Order</th> </tr> </thead> <tbody> <tr> <td>Generic Drugs on Plan Manager's Drug List</td> <td>\$10</td> <td>\$20</td> </tr> <tr> <td>Brand Name Drugs on Plan Manager's Drug List</td> <td>\$20</td> <td>\$40</td> </tr> <tr> <td>Generic &amp; Brand Name Drugs not on Plan Manager's Drug List</td> <td>\$30</td> <td>\$60</td> </tr> </tbody> </table> <p>Police (WAPPA)/Fire (IAFF) unions who retired 3-1-09 to 2-28-13; Nurses/Engineering unions who retired 3-1-11 to 12-31-11; individuals converted to Non-Rep status (former Nurses/Engineering union members who retired 1-1-12 to 2-28-12). <b>(Applies to retiree groups 47, 52, 53, 57, &amp; 59):</b></p> <table border="1" data-bbox="397 1503 964 1728"> <thead> <tr> <th></th> <th>Retail</th> <th>Mail Order</th> </tr> </thead> <tbody> <tr> <td>Generic Drugs on Plan Manager's Drug List</td> <td>\$10</td> <td>\$25</td> </tr> <tr> <td>Brand Name Drugs on Plan Manager's Drug List</td> <td>\$20</td> <td>\$50</td> </tr> <tr> <td>Generic &amp; Brand Name Drugs not on Plan Manager's Drug List</td> <td>\$30</td> <td>\$75</td> </tr> </tbody> </table> <p><b>Note: Prescriptions for equipment/items deemed medically necessary (such as, but not limited to, crutches, compression stockings, diabetic meters) are covered under the <i>Durable Medical Equipment</i> section.</b></p>		Retail	Mail Order	Generic	\$3	\$0	Brand	\$5	\$3		Retail	Mail Order	Generic Drugs on Plan Manager's Drug List	\$10	\$20	Brand Name Drugs on Plan Manager's Drug List	\$20	\$40	Generic & Brand Name Drugs not on Plan Manager's Drug List	\$30	\$60		Retail	Mail Order	Generic Drugs on Plan Manager's Drug List	\$10	\$25	Brand Name Drugs on Plan Manager's Drug List	\$20	\$50	Generic & Brand Name Drugs not on Plan Manager's Drug List	\$30	\$75	<p>70% of charges per prescription or refill; up to a 34-day supply.</p> <p>Local 80 (PW &amp; Clerical) retirees prior to 1-1-12; individuals converted to Non-Rep status (former AFSCME union members) who retired 1-1-12 to 2-29-12; retired Mayor/Alderspersons prior to 4-15-08; other retirees prior to 3-1-07: 80% of charges per prescription or refill, up to a 34-day supply.</p> <p>Not subject to deductible or annual/lifetime maximum.</p>
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PRESCRIPTION DRUGS	IN NETWORK SERVICES Retail: Express Scripts (nationwide network) Mail Order: Express Scripts	OUT OF NETWORK SERVICES												
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**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.

**RETIREE INSURANCE GROUPS AND CORRESPONDING DESCRIPTIONS  
FOR INDIVIDUALS WHO RETIRED PRIOR TO 3-1-13**

Retiree Group	Description
2	Retirees 1983 – 1987
8	Retirees before 1983
10	Retirees 1987 – 1989
11	Retirees 1990 – 1991
12	Retirees 1992
13	Retirees 1993 – 1995
15	Retirees 1/1/96 – 2/28/03; Fire Unit to 12/31/02; Police Unit to 11/30/03; Nurses prior to 8/1/04
16	Retirees Dept Hd/Elected 1/1/96 – 2/28/03
17	Retirees – Fire Unit 1/1/03 – 12/31/03
18	Retirees – Non-Reps, Local 80 (PW & Clerical) 3/1/03 – 2/28/04
19	Retirees – Dept Hds/Elected Officials 3/1/03 – 2/28/04
20	Retirees – Fire Unit & Eng. Tech. Assn. 1/1/04 – 2/28/07
21	Retirees – Non-Reps 3/1/04 – 2/28/07, Local 80: (PW & Clerical) 3/1/04 – 3/31/08
24	Retirees – Police Unit 12/1/03 – 2/28/07

**RETIREE INSURANCE GROUPS AND CORRESPONDING DESCRIPTIONS  
FOR INDIVIDUALS WHO RETIRED PRIOR TO 3-1-13**

Retiree Group	Description
42	Retirees – Dept Hds/City Atty/ Judge/Non-Reps 3/1/07 – 3/31/08; Police 3/1/07 – 2/28/09; Nurses 3/1/07 – 6/30/08; Engineers 3/1/07 – 7/31/08; Fire 3/1/07 – 2/28/09
45	Retirees – Local 80: (PW & Clerical) 4/1/08 – 2/28/11; Mayor/Aldermen 4/1/08 – 4/14/08
46	Retirees – Non-Reps/Dept Hds/City Atty/Judge 4/1/08 – 2/28/09; Mayor/Aldermen 4/15/08 – 2/28/09; Nurses 7/1/08 – 2/28/09; Engineers 8/1/08 – 2/28/09
47	Retirees – Police/Fire 3/1/09 – 2/28/11
48	Retirees – Non-Reps/Dept Hds/Elected Officials 3/1/09 – 2/28/10
49	Retirees – Non-Reps/Dept Hds/Elected Officials 3/1/10 – 2/28/11
50	Retirees – Local 80 (PW & Clerical) 3/1/11 – 2/29/12
52	Retirees – Engineers/Nurses 3/1/11 – 2/29/12
53	Retirees – Police/Fire 3/1/11 – 2/29/12
55	Retirees - Non-Reps/Dept Hds/Elected Officials 3/1/11 – 2/29/12
57	Retirees - Police 3/1/12 – 2/28/13
58	Retirees - Non-Reps/Elected Officials TO ADDITIONALLY INCLUDE former Engineers/Clerical/PW/Nurses unions 3/1/12 – 2/28/13
59	Retirees - Fire 3/1/12 – 2/28/13



## PPO PLAN BENEFIT SUMMARY FOR INDIVIDUALS WHO RETIRED ON OR AFTER 3-1-13

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>
	ANTHEM <i>Blue Priority</i> provider network for services <u>within</u> Wisconsin Service Area.  ANTHEM <i>National PPO (BlueCard PPO)</i> for services <u>outside of</u> Wisconsin.	
<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>	<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).  <b>\$40</b> Specialist visit copay (qualified practitioners not listed above).  <b>Note:</b> Co-pays are waived for Routine Preventative Services.	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.

	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 RESPIRATORY (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.

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES															
<b>MENTAL HEALTH &amp; ALCOHOL/ SUBSTANCE ABUSE:</b>																	
<b>Inpatient, Residential</b>	100% of eligible charges after deductible.	80% of eligible charges after deductible.															
<b>Outpatient Therapy and Office Visit Services</b>	100% of eligible charges; deductible is waived. Subject to applicable copay.																
<b>Partial Hospitalization</b>	100% of eligible charges after deductible.																
<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>	<b>IN NETWORK SERVICES</b> <b>Retail: Express Scripts, Inc.</b> <b>Mail Order: Express Scripts, Inc.</b>	<b>OUT OF NETWORK SERVICES</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.															
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	<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.

**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* or *Blue Preferred* Network [www.Anthem.com](http://www.Anthem.com)

If your primary residence is located in Wisconsin within Anthem's Blue Priority service area (refer to map):

- ✓ select "**Blue Priority**" when seeking care within the Blue Priority service area in Wisconsin (refer to map);
- ✓ select "**National PPO (BlueCard PPO)**" when seeking care outside of Wisconsin.

If your primary residence is located in Wisconsin but outside of Anthem's Blue Priority service area (refer to map) (Note: This option is *exclusive* to individuals who retired prior to 3-1-13):

- ✓ select "**Blue Preferred**" when seeking care in Wisconsin;
- ✓ select "**National PPO (BlueCard PPO)**" when seeking care outside of Wisconsin.

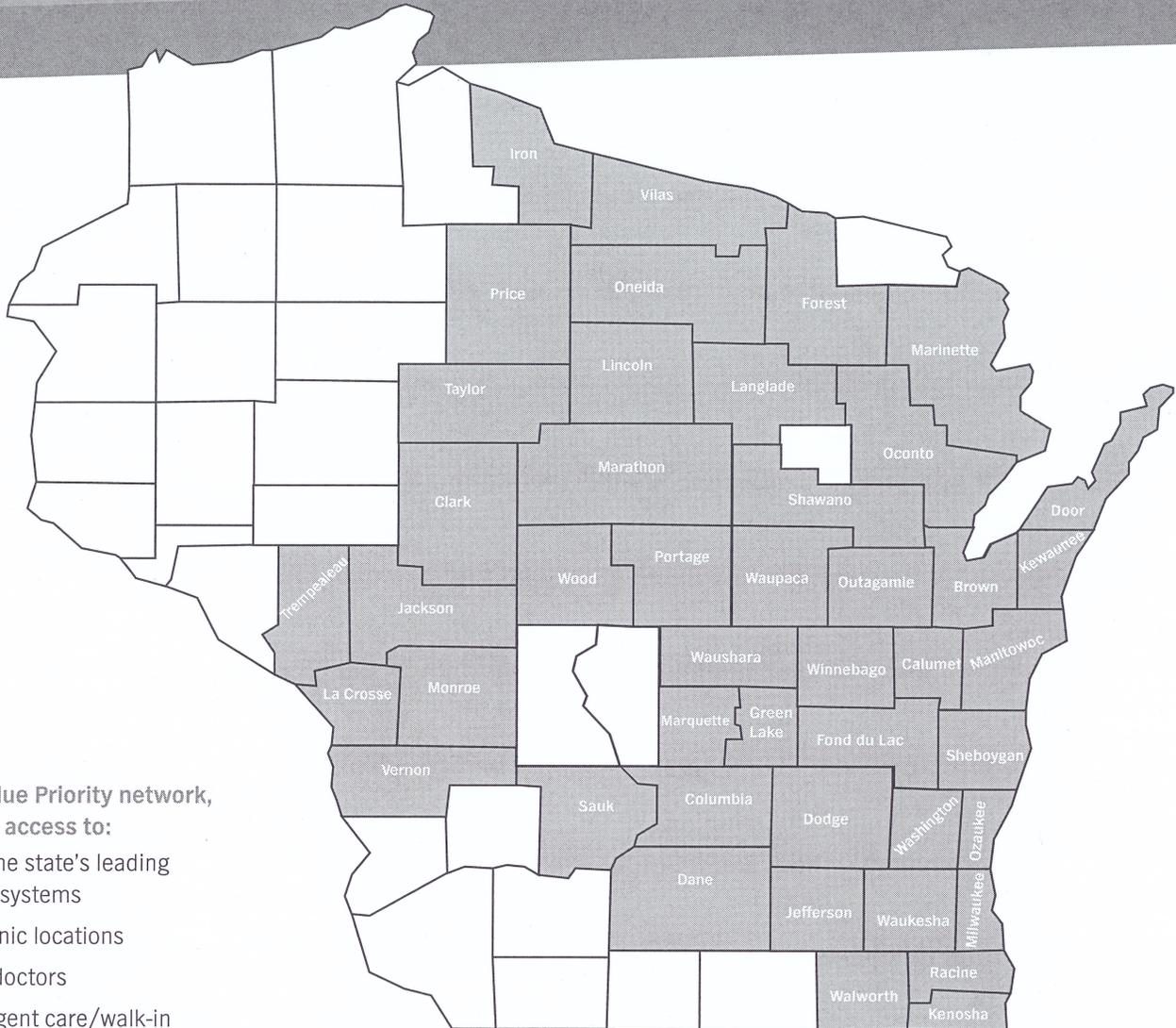
To begin your search, log into [www.anthem.com](http://www.anthem.com)

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 Priority* or *Blue Preferred* network under the "Medical Networks" option depending on your primary residence as noted above; 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

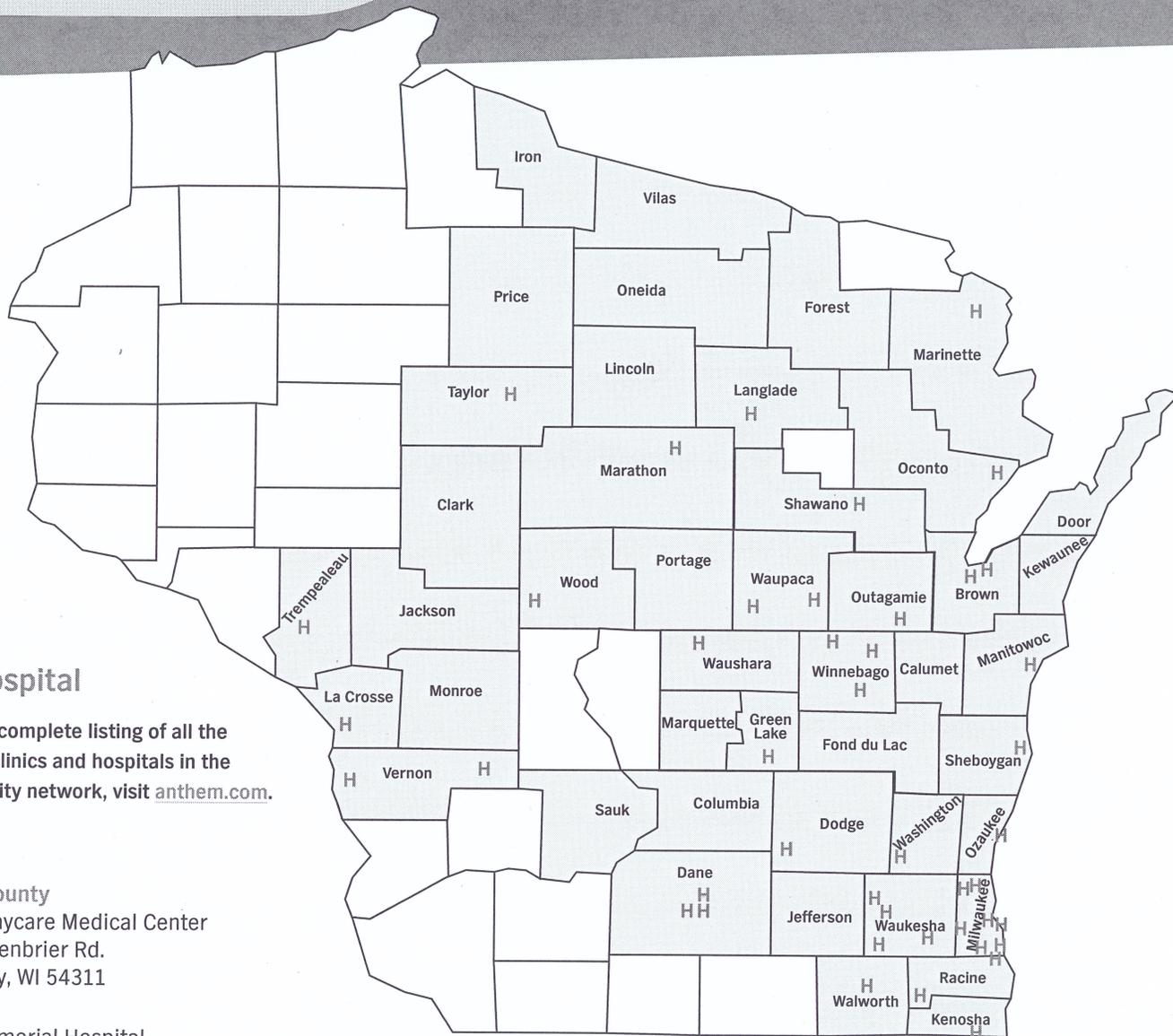
#### **Door**

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 individuals whose primary residence is located OUTSIDE Wisconsin OR 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/retirees 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 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.



# HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

This is a new plan offering. Members participating in this plan may or may not be eligible to participate in a Health Savings Account (HSA). If ineligible to participate in an HSA, you may still participate in the HDHP. (Refer to the HSA program section of this Guide.)

## Points of interest:

- ✓ Benefit levels for all plan participants are the same:
  - In-Network: plan year combined medical and prescription drug deductible of \$1,500 for a single plan participant or \$3,000 for a couple or family plan participant; thereafter you pay 20% coinsurance up to a maximum out-of-pocket (including the deductible) of \$3,000 for a single plan participant or \$6,000 for a couple or family plan participant;
  - Out-of-Network: plan year combined medical and prescription drug deductible of \$15,000 per person or \$30,000 per couple or family plan, 40% coinsurance after the deductible has been satisfied up to a maximum out-of-pocket (including the deductible) of \$30,000 per person or \$60,000 per couple or family.
- ✓ Health Care Provider network options:
  - In-Network: when seeking care in Wisconsin, select “*Blue Preferred*” 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)*” provider.
- ✓ **This plan does NOT qualify as a Medicare Part D Creditable Plan. Medicare-enrolled individuals must read the documents entitled, “*Medicare Part D Notice of Non-Creditable Coverage*” and “*High Deductible Health Plan (HDHP) Medicare Part D Notice of Non-Creditable Coverage*” for additional information on how this may affect you.**
- ✓ Pharmacy Provider (Members will be required to obtain all new prescriptions for mail order and specialty pharmacy prescriptions):
  - 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.

## 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. It is imperative you read the documents entitled, "*Medicare Part D Notice of Non-Creditable Coverage*" and "*High Deductible Health Plan (HDHP) Medicare Part D Notice of Non-Creditable Coverage*" to determine how this may affect you.



## HIGH DEDUCTIBLE HEALTH PLAN (HDHP) BENEFIT SUMMARY for Retirees

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. <i>Payment of services will depend on how providers bill.</i></p>	<p>No dollar limit. <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 for Retirees

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
<b>URGENT CARE FACILITY</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>PHYSICIAN OFFICE VISITS (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>DIAGNOSTIC X-RAY, LAB SERVICES (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>INJECTIONS</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>ALLERGY CARE</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>PODIATRY SERVICES (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>HEARING EXAM (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>EYE EXAM (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>MATERNITY</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>PEDIATRIC CARE (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>HEALTH EDUCATION &amp; COUNSELING (Non-Routine)</b>	80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>ORAL SURGERY</b>	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.
<b>MENTAL HEALTH &amp; ALCOHOL/ SUBSTANCE ABUSE:</b>  <b>Inpatient, Residential</b>  <b>Outpatient Therapy and Office Visit Services</b>  <b>Partial Hospitalization</b>	80% of eligible charges after deductible.  80% of eligible charges after deductible.  80% of eligible charges after deductible.	60% of eligible charges after deductible.
<b>CHIROPRACTIC CARE</b>	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.
<b>PHYSICAL THERAPY</b>	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.
<b>OCCUPATIONAL THERAPY</b>	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 for Retirees

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
<b>THERAPIES – CARDIAC, CHEMO, DIALYSIS/ HEMODIALYSIS, INFUSION RADIATION, AND RESPIRAORY (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 for Retirees

**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  
methyclothiazide  
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 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/retirees 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.

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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 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 retirees 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 retiree 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. Retirees wishing to enroll in an Health Savings Account MUST complete Tri-City National Bank's HSA Application Information Form and return it to the Finance Department **NO LATER THAN 5:00 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 tax savings:

1. Tax-free withdrawals for qualified medical expenses
2. Tax-free earnings through investment

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 your medical coverage 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

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

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

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](http://anthem.com) to access your benefits\*



From your computer



Go to [anthem.com](http://anthem.com)  
and select **Register Now**



Provide the personal  
information requested



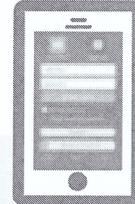
Create a username and password



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.

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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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## The Estimate Your Cost tool is easy to use

Just follow these steps to get the information you want:

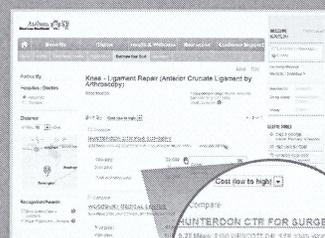
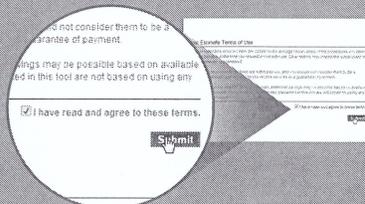
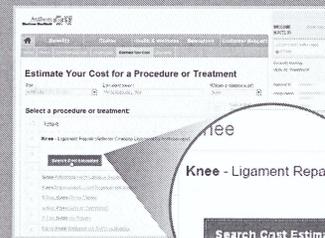
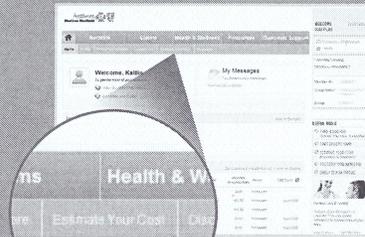
1. Log in to [anthem.com](http://anthem.com).

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.



You pay:	\$2,894
Plan pays:	\$0.042
<b>Total estimated cost:</b>	<b>\$8,035</b>

# 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>5</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.

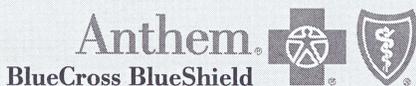
#### 2. Visit your pharmacy.

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.

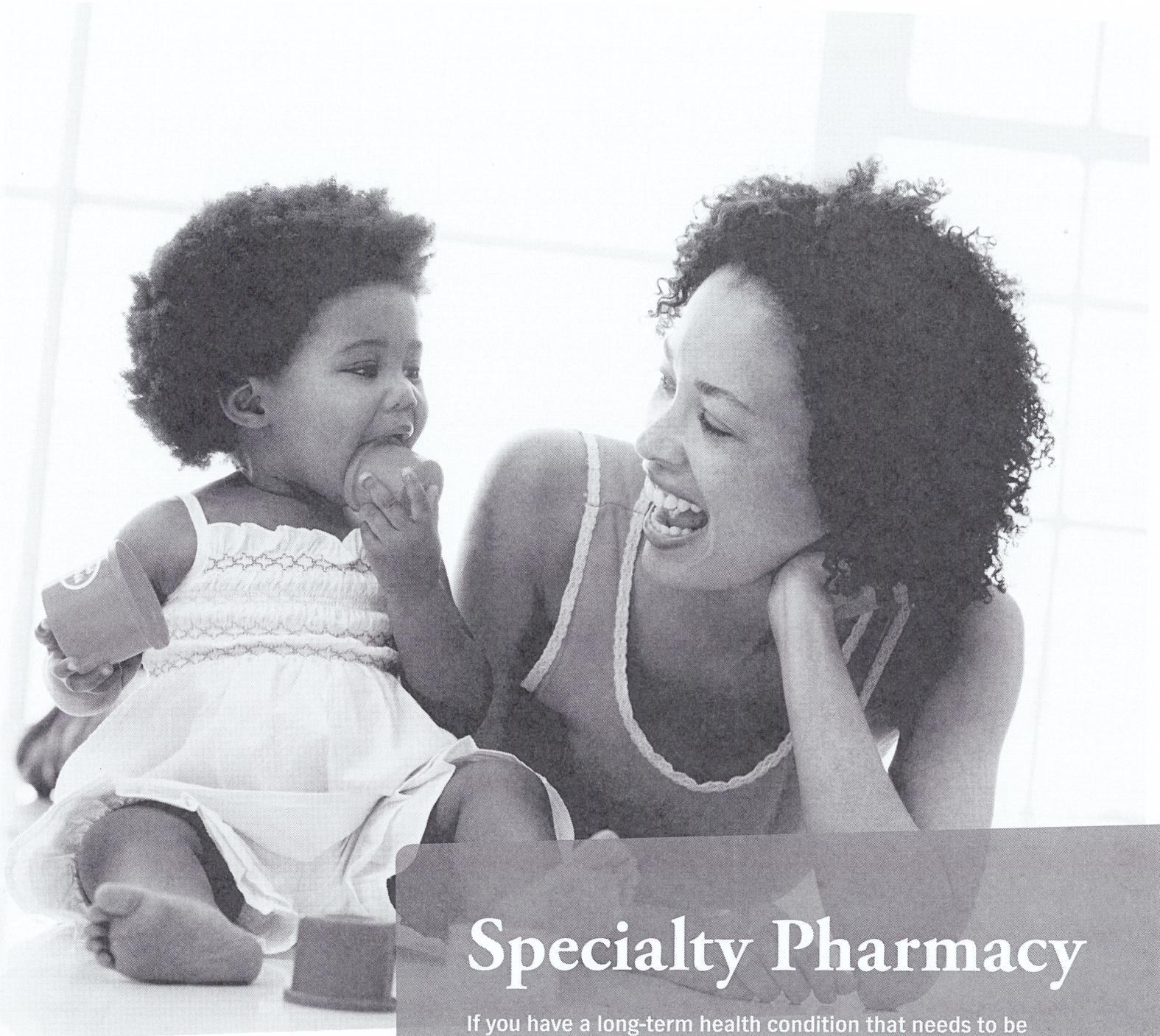
## Need help getting started?

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.**

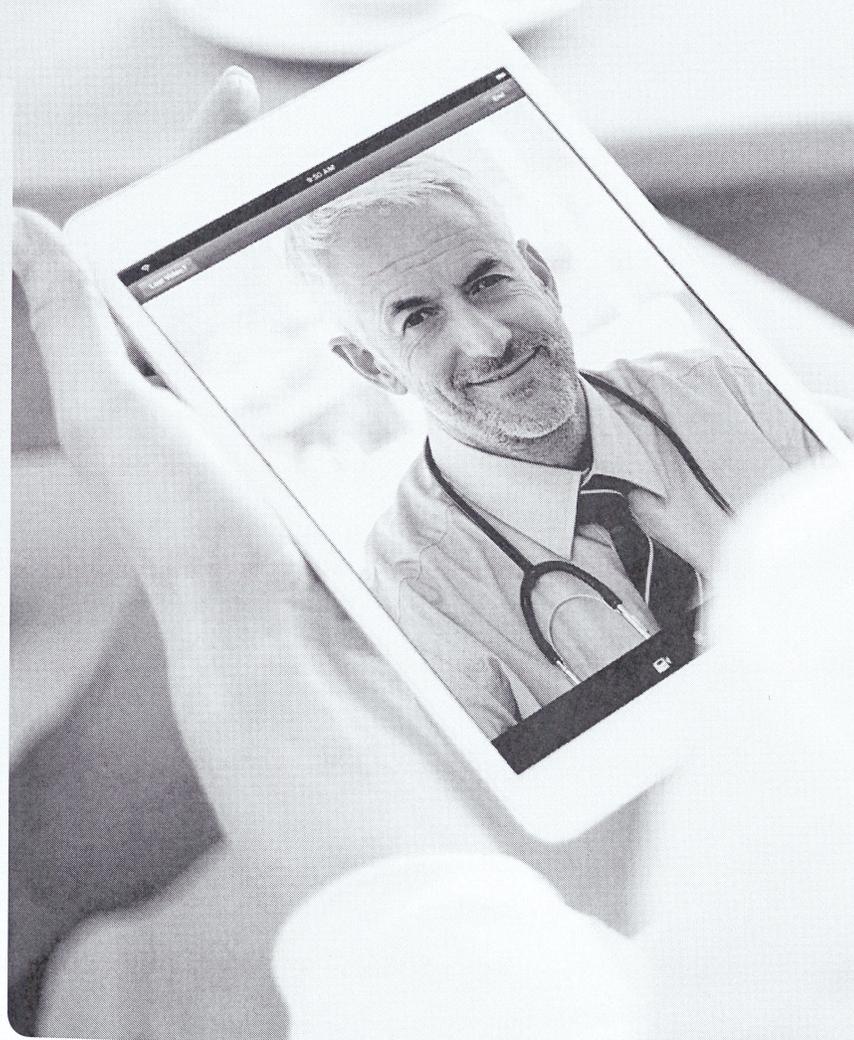
**85% of members like you would recommend  
24/7 NurseLine to others.**



# 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.



LiveHealth<sup>®</sup>  
ONLINE

## 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.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

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. 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.

# 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.

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<sup>®</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>®</sup> 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.



## 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.\*

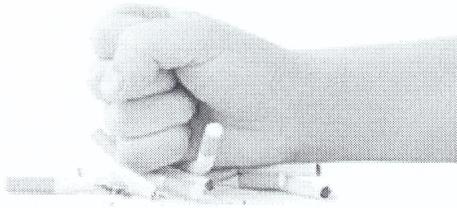


\*Source: 2010 Membership Satisfaction Studies

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MANSH3152A Rev. 11/11 F0023836



## 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?

The City continues to offer coverage for smoking/tobacco cessation treatment; the lifetime limits on smoking/tobacco cessation prescription drugs, over-the-counter products, and counseling/treatment programs conform to federal health care reform.

- **If retired prior to 3-1-12:** over-the-counter smoking/tobacco cessation products and prescription drugs are covered up to a lifetime maximum benefit of \$500 with no copay.
- **If retired 3-1-12 to 2-28-15:** over-the-counter smoking/tobacco cessation products and prescription drugs are covered up to a 90-day supply annually with no copay.
- **If retired on or after 3-1-15:** over-the-counter smoking/tobacco cessation products and prescription drugs are covered annually with no quantity limits and with no copay.
- Individuals are also eligible for an additional \$500 lifetime maximum benefit for smoking cessation counseling and tobacco use treatment programs. (Telephonic and in-person counseling are covered.)

Prescription drugs and any OTC products for the treatment of smoking/tobacco cessation are covered through your prescription drug program. **You will need to request a prescription from your physician and then have the prescription filled in the normal fashion at your local pharmacy.** Prescriptions may only be filled at the retail level. Mail order is not an option for this program.

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

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



# **RETIREEES with MEDICARE**

Alternatives to the City's Plan Offerings



***Business Partnership with Allied Senior Services Insurance & Investments LTD.***

Willis Towers Watson has partnered with Allied Senior Services to assist you in exploring individual health insurance coverage options.

If you're confused about what to do when it comes to insurance, it's time to stop worrying. The professionals at Allied Senior Services offer free overviews of current coverage and policies. Representatives have been in business since 1989, servicing all ages.

Allied Senior Services is a full service insurance agency handling many types of insurance from several companies. They meet your individual needs by shopping for the best product and the best price. For more information on independent health insurance plans, Medicare supplements, long term care insurance, etc., contact:

**Annamarie Blawat**  
**Allied Senior Services Insurance and**  
**Investments LTD., Inc.**  
**7421 W Becher St**  
**Milwaukee, WI 53219**  
**[ablawat@allied-senior-scvvs.com](mailto:ablawat@allied-senior-scvvs.com)**  
**Phone: 414-545-7878**  
**Toll Free: 800-924-4061**  
**Fax: 414-545-0767**  
**<http://www.alliedseniorservices.com/>**

Willis Towers Watson is confident their business partner will take care of your individual and family needs with the highest quality and service.



# **REQUIRED NOTIFICATIONS**



## **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.

# 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

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

# 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

## **FORM 1095C**

Effective for tax year 2015, the IRS requires employers to issue a Form 1095-C for any retirees 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.

## **ANNUAL/LIFETIME LIMITS**

The annual/lifetime out-of-network limit on the dollar value of benefits under the City of West Allis' health plan is as follows:

- \$1,000,000 if retired prior to March 1, 2012
- \$1,250,000 if retired March 1, 2012 through February 28, 2013
- \$2,000,000 if retired March 1, 2013 through February 28, 2014
- No limit if retired on or after March 1, 2014

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

Under the Medicare, Medicaid, and SCHIP Extension Act of 2007, the City is required to report the social security numbers of all employees/retirees and spouses/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.

## **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).

## 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.

<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.

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.

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 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 1-866-444-3272. 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 1-800-318-2596 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.

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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.