MPS Summary of Benefits

Information Regarding Your Employee Benefits

Publication Date: July 1, 2013 • Updated January 1, 2024

This summary of benefits is periodically updated.
You will find the most recent version on the MPS website.

Office of Human Resources
Department of Benefits, Pension & Compensation

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INTRODUCTION

This summary of benefits is intended to provide you with an overview of the benefits available to you as an employee of Milwaukee Public Schools (MPS) and is a companion piece to the MPS Employee Handbook effective July 1, 2013. This summary is periodically updated. You will find the most recent version on *mConnect* at https://mconnect.milwaukee.k12.wi.us, then select Summary of Benefits under Quick Links on the Home page. Other information sources, including the District's Open Enrollment Benefit Plans Booklet for Active Employees, can also be found on *mConnect* and provides the most up to date benefits information.

This summary applies to the following MPS employee units:

(1) Administrators and Supervisors unit	(14) Office of Board Governance
(2) Exempt Administrators and Supervisors	(15) Part-time Recreation Employees unit
(3) Board Members	(16) Psychologists unit
(4) Bookkeepers/Accountants unit	(17) Substitute Teachers unit
(5) Building Engineers unit	(18) Superintendent
(6) Building Service Helpers unit	(19) Teachers unit
(7) Building Trades unit	(20) Temporary Employees, Limited Term Employees (LTE)
(8) Cabinet Level	(21) Warehouse and Distribution Services Buyers, F&M Services, Grounds Keeper, Seasonal Laborers, Parent Information Specialist, Social Work Aides, Radio and TV and Technology unit
(9) Clerical-Technical unit	(22) Management Interns
(10) Exempt from Clerical-Technical unit	(23) Supplemental Teachers
(11) Educational Assistants/Safety Assistants unit	(24) Part-time Teachers
(12) Food Service, CHA, SNA unit	(25) Substitute Teachers Eligible for Benefits
(13) Office of Accountability and Efficiency	(26) Emerging Educator

Throughout this summary, eligibility or access restrictions applicable to the various benefit programs are listed by employee unit at the end of the section that describes the benefit. For example, the following shows the employee units that are not eligible for the Health Insurance Opt-Out benefit.

Note: Eligibility Restrictions for Health Insurance Opt-Out
> (3) Board Members are not eligible for the Opt-Out benefit.
> (15) Part-time Recreation Employees are not eligible for Opt-Out benefit.
> (17) Active Substitute Teachers are not eligible for the Opt-Out benefit effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for Opt-Out benefit.
> (24) Part-time Teachers are not eligible for Opt-Out benefit.
> Seasonal Laborers are not eligible for the Opt-Out benefit effective with dates of hire or layoff on or after 7/1/12.

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

HEALTH AND DENTAL BENEFIT ELIGIBILTY

When Health and Dental Coverage Begins

Employees regularly scheduled to work in benefit-eligible positions of 30 or more hours per week are eligible for health and dental insurance, single or family coverage.

Health and dental coverage for a new or returning employee begins on the first day of the month following one (1) month of employment. To enroll in health and/or dental coverage, a completed MPS benefit application must be submitted through self-service within 31 calendar days after beginning employment or return from leave. Applications received later than thirty-one (31) calendar days after the first day of employment shall not be accepted. If you do not enroll when first eligible, you only have the opportunity to do so at the next open enrollment period or with an applicable qualifying event (also referred to as Family Status Changes). Instructions for completing your application as a new hire can be found by going to mpsmke.com, clicking Careers and then New Hire Information.

Coverage start date examples are:

Hire Date or Return from Leave:	**Health/Dental/Vision Begins if enrolled:**
August 29th	October 1st
May 10th	July 1st
November 4th	January 1st
April 1st	May 1st*
* If you are hired/return from leave on the 1st of the month, your coverage begins the 1st of the next month.	

To obtain health insurance coverage as of the first day of employment, a completed MPS benefit application/change form along with payment of one month's total monthly premium **(see APPENDIX D for rates)** must be submitted within 15 calendar days of the first day of employment. **Please Note:** "First day of employment" means employment of a newly hired employee in a benefit-eligible position. The Benefit Application/Change Form can be found by going to mpsmke.com and searching "Benefit Application."

Coverage for 10-month school year employees (including IB/early start and traditional) who work/are paid through the end of their regularly scheduled school year will receive active employee coverage through August 31st, and, for school year employees returning within the first 10 work days of the next school year, coverage will be continuous.

Employees may choose between the MPS PPO Health Plan, the MPS EPO Health Plan, or the MPS High Deductible Health Plan (HDHP), administered by United Healthcare (UHC). A highlight summary of benefits for each plan is provided in APPENDIX A. For additional information describing the MPS PPO, EPO, and HDHP health plans, please visit the Department of Benefits, Pension & Compensation site on *mConnect*. From the Home page select: Departments>Benefits, Pension & Compensation> Benefits Enrollment (under "Quick Links")> 2024 Open Enrollment Benefit Plans Booklet for Active Employees.

Note: Eligibility Restrictions for Health and Dental Benefits
> (7) Building Trades only have access to the EPO and HDHP health plans.
> (15) Part-time Recreation Employees are not eligible for health and dental benefits.
> (17) Active Substitute Teachers are not eligible for health and dental benefits effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for health and dental benefits.
> (24) Part-time Teachers are not eligible for health and dental benefits.
> Seasonal Laborers are not eligible for health and dental benefits effective with dates of hire or layoff on or after 7/1/12.

Eligibility for Spouse & Children

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

- **Spouse** is the person to whom the subscriber is legally married.
- **Dependent Child** includes the following:
    - Natural or adopted child of the subscriber.
    - Stepchild - is the natural or adopted child of the subscriber's spouse for whom the subscriber and/or spouse provide more than 50% of the child's support during a calendar year.
    - Legal Ward - is a child for whom the subscriber or current spouse is the legal guardian and for whom the subscriber and/or spouse provide more than 50 percent of the child's support during a calendar year.
- **Grandchild** - is a child of the subscriber's dependent child for whom the subscriber and/or spouse provide more than 50 percent of the grandchild's support during a calendar year when the grandchild's parent is under age 18.

Adult Child Dependent Eligibility – As a result of state and federal mandated changes* to health and dental coverage, adult dependent children (age 19 and older) must meet coverage eligibility as outlined below. These mandates **do not require you** to cover your adult children under your MPS health and/or dental plan.

- Adult child is between the ages 19 to 26.
- Adult child can be single or married.
- Per State mandate, eligibility requirements also include the adult child who is a full-time student regardless of age **and** was under age 27 years when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.
- Application for disabled dependents continuation of health and dental coverage must be completed prior to turning age 26.

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

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

Note: 1. Employees shall not be entitled to duplicate coverage under any other health, vision, pharmacy or dental insurance plan offered by the Board.

2. If you are an employee who is also covered as an eligible dependent under another MPS health plan, MPS Department of Benefits will terminate the dependent coverage and continue only your current employee coverage.

To make a change to your coverage due to a Family Status Change, go to the MPS homepage mpsmke.com, click the staff menu in the top blue bar and log in to Self Service. Then click the Benefit Details tile > Life Events tile > and make your selection from the list of life events and follow the instructions. Detailed instructions can be found on *mConnect* under Benefits Resources called Benefits Family Status Change- Self Service Instructions. Changes must be made within 31 calendar days of a qualifying family status change event, 60 calendar days for birth, adoption, or loss of Medicaid or State Children's Health Insurance Plan (CHIP).

Adding New Dependents

Family Status Changes/Life Events are now done on MPS Employee Self Service! If you have a family status change (marriage, birth of a child, adoption, divorce, etc.) and would like to make changes, go to the MPS homepage mpsmke.com, click the staff menu in the top blue bar and log in to Self Service. Then click the Benefit Details tile > Life Events tile > and make your selection from the list of life events and follow the instructions. Detailed instructions can be found on mConnect under Benefits Resources called Family Status Changes-Self Service Instructions. Changes must be made within 31 calendar days of a qualifying family status change event, 60 calendar days for birth, adoption, or loss of Medicaid or State Children's Health Insurance Plan (CHIP).

Adding a Dependent – MPS Department of Benefits, Pension & Compensation must be notified within 31 calendar days of the event (this is referred to as a Family Status Change). If notification is received within 31 calendar days, dependent coverage shall be effective on the date of the qualifying event; otherwise, the new dependent may be added only during an open enrollment period. Examples of the above would be a marriage or return of a child to dependent status. If a dependent loses Medicaid or CHIP coverage they may be added within 60 calendar days.

Birth or Adoption of a Child – as the parent, you must file a new application online through Self Service with MPS Department of Benefits, Pension & Compensation **within 60 calendar days of the date of birth or placement.** A copy of the birth certificate or adoption papers must also be submitted during the application process. The 60-calendar day automatic coverage period commences as of the date of birth and only applies to newborns and does not apply to adopted children.

If you are enrolling any dependent(s) you must submit verification of dependent eligibility. For example, if you are enrolling a spouse you must submit a marriage certificate/license; for dependent child(ren) you must submit the birth certificate(s). Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation will delay processing of your eligible dependent(s). If verification is not received within 31 calendar days of our written request, the dependent will not be enrolled and will have to wait until the next open enrollment period to enroll.

After initial enrollment and open enrollment, additions, terminations, and changes will only be allowed to your MPS health/vision and dental plans as the result of a Family Status Change. The following is a list of the most common family status changes and the documentation needed from you to make a change:

Family Status Change	**Copy of Document or Notice Required**
Marriage	Marriage certificate/license (must be registered certified state copy)
Birth	Birth certificate or proof that the birth certificate is registered.
Adoption	Court adoption or adoption agency placement letter.
Divorce	Notification of date of divorce.
Death	Notification of date of death.
Loss of Other Insurance Coverage	HIPAA notice of coverage loss.

If you are dropped from other coverage due to divorce, you have 31 calendar days to enroll in an MPS plan with proof of loss of coverage. **Please see the 2024 Benefit Plans for Active Employees Booklet for a detailed list of Family Status Changes/Life Events and allowable changes (saved on mConnect).**

Open Enrollment for Health and Dental Coverage

The annual open enrollment period will be held during October/November each year with plan coverage effective January 1st. Open enrollment materials will be distributed to eligible employees in late October. Look for the specific dates and deadlines for Open Enrollment on the MPS website and in printed materials. The open enrollment period allows active employees who are eligible to enroll in a health and/or dental plan to add dependents or change health and/or dental plans. The open enrollment period also allows current enrolled retirees and surviving spouses to change health plans and retirees with family health plan coverage to add dependent children. Please note: Currently, our Medicare eligible retirees/spouses and their dependents have one health care plan option, the MPS Group Medicare Advantage plan. Current employees can enroll in Opt-Out during Open Enrollment. See page 11 for more information about the Opt-Out plan.

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

You are required to notify MPS Department of Benefits, Pension & Compensation of events such as a divorce or death of spouse or dependent, in order to remove ineligible dependents from your plan. In the case of divorce, your ex-spouse and your step-child(ren) from that marriage are no longer eligible to be covered as your dependents and you must remove them from your MPS health and dental plan within 31 calendar days.

MPS reserves its rights to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud.

When Health and Dental Coverage Ends

Board-paid health and dental coverage for the employee and all dependents ceases on the last day of the month following the month in which the employee becomes ineligible due to non-payment of the required employee premium contribution, termination, suspension, resignation, layoff, move into a non-benefit eligible position, or unpaid status for more than one-half the number of paid work days in a calendar month. However, for Early Start and Traditional School Calendar employees who lose eligibility at the end of their regularly scheduled school year, health and dental coverage ceases on August 31 following the loss of eligibility.

As per Board policy/procedures, Plan provisions, and state/federal mandates coverage ceases for dependents as follows:

- Spouse - coverage ends at the end of the month in which the spouse is no longer legally married to the subscriber.
- Dependent Child
  (1) End of the month in which adult child attains age 26 per current state and federal mandates in effect as of the date of this publication.
  (Note: See page 5 Adult Child Dependent Eligibility for additional details.)
  Health/Vision and Delta Dental Plans- coverage ends at the end of the month in which the child attains age 26, regardless of support, unless prior to attaining age 26 the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the subscriber and/or subscriber's spouse for support and maintenance. Proof of such incapacity and dependency must be furnished by the subscriber to the employee's health plan, at no expense to the employee's health plan, within 31 calendar days of the child's attainment of age 26, and subsequently when and as often as the employee's health plan may reasonably require but not more frequently than annually after the two-year period following the child's attainment of age 26.

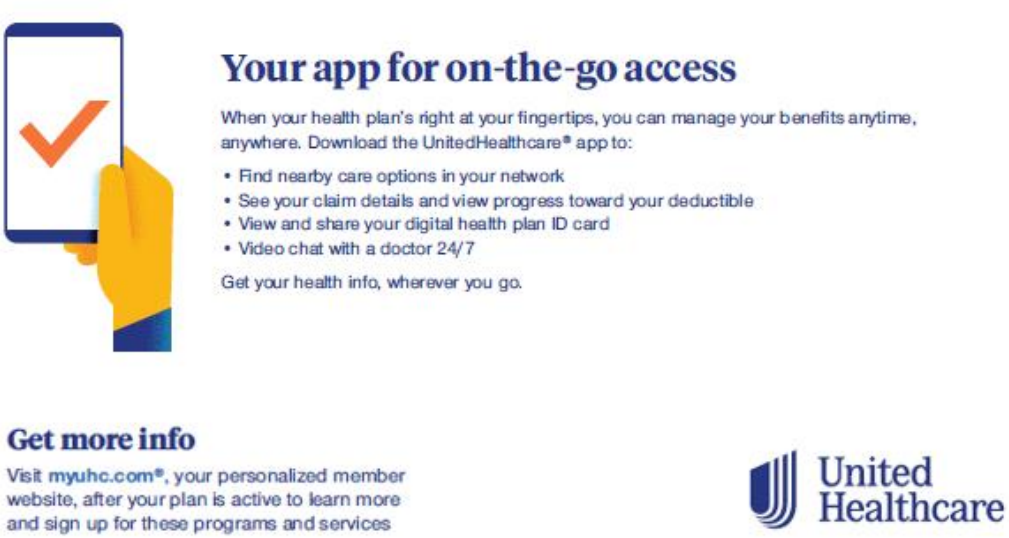
(2) Grandchild - coverage ends at the end of the month when the grandchild's parent loses dependent status or the grandchild's parent turns 18 or the subscriber and/or spouse no longer provide more than 50 percent of the grandchild's support.
(3) Loss of legal status - coverage ends at the end of the month in which the child no longer meets the definition of stepchild or legal ward. For example, a stepchild's parent is no longer legally married to the subscriber; legal ward's coverage ends at age 18.
(4) Emancipation - coverage ends at the end of the month in which the child is legally emancipated, even if the emancipation occurs prior to the attainment of age 19.

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

HEALTH AND PRESCRIPTION BENEFITS

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

APPENDIX A includes a grid summarizing the benefits and costs associated with the plan; APPENDIX D includes a listing of the monthly premium costs and per-paycheck deductions for each health plan.



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

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

Reminders for EPO and PPO Plans

Out-of-Pocket Maximum for EPO and PPO

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

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

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

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

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

Preauthorization Requirement on the EPO, PPO and HDHP Plans

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

Special Notes on the HDHP Plan

The HDHP plan offers employees a health plan with a lower monthly premium cost in exchange for a higher deductible within the plan and the ability to open a Health Savings Account (see page 12 for more information). This gives employees greater control of how they manage their health care costs and an opportunity to save money with a tax advantage.

How does the HDHP deductible work?

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

How are preventive medical services covered under the HDHP?

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

How are medications covered under the HDHP?

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

HDHP Out-Of-Pocket Maximum (OOP)

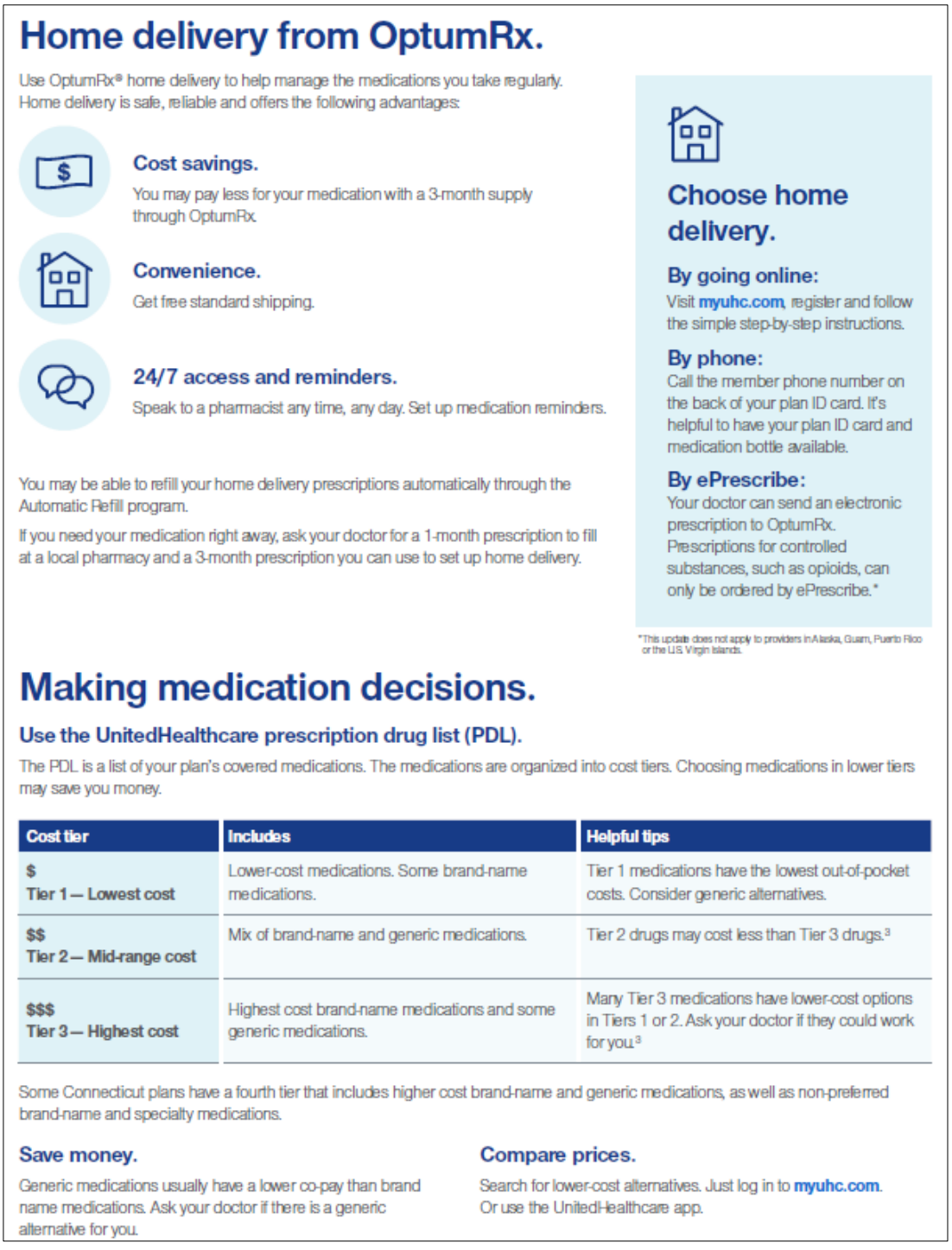
Unlike the other health plans, the HDHP has a combined prescription drug and medical Out-Of-Pocket maximum. All member deductible, coinsurance and co-pays for covered medical expenses and prescription drugs apply toward the Out-Of-Pocket maximum. Once the Out-Of-Pocket limit has been satisfied, there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

How do I know which plan is best for me?

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

OptumRx

Retail pharmacy and home delivery (mail order) coverage with the EPO, PPO, and HDHP remains the same in 2024. The prescription drug list (PDL) coverage information is updated twice per year and can be found on *mConnect* and myuhc.com. To find information about OptumRx home delivery, prescription drug prices, and more: log in to myuhc.com and select "Pharmacies & Prescriptions." Here are some highlights of the home delivery coverage from OptumRx and the PDL:



Home delivery from OptumRx.

Use OptumRx® home delivery to help manage the medications you take regularly. Home delivery is safe, reliable and offers the following advantages:

Cost savings.

You may pay less for your medication with a 3-month supply through OptumRx.

Convenience.

Get free standard shipping.

24/7 access and reminders.

Speak to a pharmacist any time, any day. Set up medication reminders.

You may be able to refill your home delivery prescriptions automatically through the Automatic Refill program.

If you need your medication right away, ask your doctor for a 1-month prescription to fill at a local pharmacy and a 3-month prescription you can use to set up home delivery.

Choose home delivery.

By going online:
Visit **myuhc.com**, register and follow the simple step-by-step instructions.

By phone:
Call the member phone number on the back of your plan ID card. It's helpful to have your plan ID card and medication bottle available.

By ePrescribe:
Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe.*

*This update does not apply to providers in Alaska, Guam, Puerto Rico or the U.S. Virgin Islands.

Making medication decisions.

Use the UnitedHealthcare prescription drug list (PDL).

The PDL is a list of your plan's covered medications. The medications are organized into cost tiers. Choosing medications in lower tiers may save you money.

Cost tier	Includes	Helpful tips
$ Tier 1 — Lowest cost	Lower-cost medications. Some brand-name medications.	Tier 1 medications have the lowest out-of-pocket costs. Consider generic alternatives.
$$ Tier 2 — Mid-range cost	Mix of brand-name and generic medications.	Tier 2 drugs may cost less than Tier 3 drugs.[3]
$$$ Tier 3 — Highest cost	Highest cost brand-name medications and some generic medications.	Many Tier 3 medications have lower-cost options in Tiers 1 or 2. Ask your doctor if they could work for you.[3]

Some Connecticut plans have a fourth tier that includes higher cost brand-name and generic medications, as well as non-preferred brand-name and specialty medications.

Save money.

Generic medications usually have a lower co-pay than brand name medications. Ask your doctor if there is a generic alternative for you.

Compare prices.

Search for lower-cost alternatives. Just log in to **myuhc.com**. Or use the UnitedHealthcare app.

Health Insurance Opt-Out

If you are eligible and covered by another employer's health insurance, you may choose not to be covered by Milwaukee Public Schools health insurance and receive $50 per month (up to $500 per year pro-rated on a 10-month basis). In order to be eligible for the Opt-Out option, eligible employees must provide (1) Annual Verification of current health coverage under another employer group health plan and (2) Attestation of you and your tax family's (as defined by the IRS) having Minimum Essential Coverage (MEC) as defined by the Affordable Care Act (ACA). For more information about tax family/dependents go to www.irs.gov/uac/who-can-i-claim-as-a-dependent. For more information regarding MEC go to www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-minimum-essential-coverage. Please note that a copy of your ID card is not accepted as proof of other coverage. If your other insurance is through a government program like Tri-Care, the VA, or BadgerCare, or if you are already covered under MPS, you are not eligible for this program.

The Opt-Out plan will not automatically roll-over from year to year. All employees must provide the required documentation when enrolling into this plan for the first time and during Open Enrollment. For further information, please contact MPS Department of Benefits, Pension & Compensation or search *mConnect* for Opt Out Info & Form for 2024.

This option is only available within the first 31 calendar days of eligibility, during the annual open enrollment period or within 31 days of becoming eligible for coverage under a different employer due to a Family Status Change.

Opt-Out plan during a leave of absence: Please note that if you are enrolled in Opt-Out and you go on an unpaid leave of absence, your Opt-Out option will terminate as soon as you have no active pay. If you are on FMLA, your Opt-Out plan will automatically be reinstated once you return to work. For any non-FMLA leave, you will need to re-enroll and provide proof of other coverage once you return to work.

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

Note: Eligibility Restrictions for Health Insurance Opt-Out
> (3) Board Members are not eligible for the Opt-Out benefit.
> (15) Part-time Recreation Employees are not eligible for Opt-Out benefits.
> (17) Active Substitute Teachers are not eligible for the Opt-Out benefit effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for Opt-Out benefits.
> (24) Part-time Teachers are not eligible for Opt-Out benefits.
> Seasonal Laborers are not eligible for the Opt-Out benefit effective with dates of hire or layoff on or after 7/1/12.

DENTAL BENEFITS

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

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

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

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

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

Note: Eligibility Restrictions for Dental Benefits
> (15) Part-time Recreation Employees are not eligible for dental benefits.
> (17) Active Substitute Teachers are not eligible for dental benefits effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for dental benefits.
> (24) Part-time Teachers are not eligible for dental benefits.
> Seasonal Laborers are not eligible for dental benefits effective with dates of hire or layoff on or after 7/1/12.

VISION BENEFITS

If you are an active employee and enrolled in a MPS health plan, you will also be automatically enrolled in and receive routine vision coverage through National Vision Administrators (NVA). This routine vision coverage is an in-network benefit only, so you must see a NVA provider to receive coverage. When enrolled, NVA will provide you with an identification card. For a list of network providers, please visit **www.e-nva.com.**

Note: Vision benefits are not offered on a free-standing basis (e.g. can't be unbundled from the health plan) and retirees are not eligible for this vision coverage through NVA. For coverage details please see APPENDIX C: VISION.

NVA Member Mobile App
Vision Benefits on the Go

Get the free NVA vision benefits member mobile app for your iPhone or Android at:

Download on the App Store

GET IT ON Google Play

Note Eligibility Restrictions for Health/Vision Benefits:
> (15) Part-time Recreation Employees are not eligible for health/vision benefits.
> (17) Active Substitute Teachers are not eligible for health/vision benefits effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for health/vision benefits.
> (24) Part-time Teachers are not eligible for health/vision benefits.
> Seasonal Laborers are not eligible for health/vision benefits effective with dates of hire or layoff on or after 7/1/12.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is an employee-owned bank-account that allows employees to save money in a tax advantaged account toward current and future medical expenses (and potentially save toward retirement). If you are an active employee, you elect the HDHP plan during the annual open enrollment and you are eligible to open an HSA account, then MPS will provide a lump sum contribution as follows: $400 for a single plan and $800 for a family plan into your HSA account. Employees must be enrolled in the HSA plan as of January 1st to receive the employer contribution. Maximum contribution amounts for 2024 are $4,150 for individuals and $8,300 for families.

OPTUM Bank®

Please note: Employees who enroll mid-year or who experience a mid-year enrollment change will not receive an MPS employer contribution or a change in the MPS employer contribution level. You, as the subscriber, must be

enrolled in the active HDHP option effective January 1 of the current year in order to receive the MPS employer contribution.

You are eligible to open an HSA account if you are enrolled in the District's HDHP plan and:

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

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

During the year, you can make changes to your HSA contribution on Employee Self Service. Go to the MPS homepage: mpsmke.com and click the staff menu in the top blue bar and log in to Self Service. Then click the Benefit Details tile > Life Events tile > select Make mid-year election change to Health Savings Account (HSA) from the list of life events. You can also find the step-by-step instructions on *mConnect* under Benefits Resources.

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

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

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

At the end of the year, all funds in the HSA account remain in the account and are owned by the employee. Even if you are no longer enrolled in a qualified HDHP, you can continue to spend the money on qualifying medical expenses without penalty. You can take the HSA with you if you change jobs or are no longer employed by MPS. Please note that you will be responsible for paying the monthly account fee when you are no longer enrolled in the MPS HDHP.

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

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

This is a voluntary program to help offset higher health care expenses and is available to all Active employees who are enrolled as the Subscriber in a MPS Health Plan. **For more information about this plan, please see the Flexible Spending Account booklet on *mConnect* under Benefits Resources.**

PROGRAM HIGHLIGHTS

- You can contribute as little as $100 or up to $3,050 annually
- P&A Group is the Third-Party Administrator for Flexible Spending Accounts (FSA)
  - Website: www.padmin.com, Customer Service #1-800-688-2611
- Plan participants will receive a Mastercard from P&A Group to pay for eligible expenses
- You can carryover up to $610 of unused Health FSA funds into the next plan year
- Your contribution is automatically deducted from your paycheck BEFORE TAXES
- Program Plan Year is from January 1 through December 31
- This is an **Internal Revenue Service (IRS) regulated program** and there are certain rules you need to know about and follow:
  - You need to make your annual election within 31 days of benefit eligibility or during the annual open enrollment period
  - You cannot transfer money between your Healthcare and Dependent Care FSA accounts, even if the enrollment in a plan was in error
  - Claims can only be reimbursed for eligible expenses you incur during the plan year
  - You cannot pay off outstanding bills incurred prior to your plan year
  - You have 90 days after the plan year end of December 31st to submit expenses from the previous plan year for reimbursement

Save all your receipts & Explanations of Benefits (EOB's)- the IRS requires that all health-related expenses purchased be validated by you.

How do you enroll for MPS Health FSA? See instructions in your new hire packet.

Note: Eligibility Restrictions for Health FSA Benefits
> (15) Part-time Recreation Employees are not eligible for health FSA benefits.
> (17) Active Substitute Teachers are not eligible for health FSA benefits effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for health FSA benefits.
> (24) Part-time Teachers are not eligible for health FSA benefits.
> Seasonal Laborers are not eligible for Health FSA benefits effective with dates of hire or layoff on or after 7/1/12.

Healthcare FSA $610 Carryover

If you were an active participant in the Healthcare FSA plan through the end of the calendar year, and you are unable to use all of your contributed funds, you can carryover up to $610 of unused funds that you can use for eligible expenses incurred during the next plan year. Even if you didn't choose to re-enroll in the plan year, once the carryover is executed, an account will automatically be created for you so that you may continue to use your previous year balance (up to $610). This helps to minimize the risk that you may forfeit unused account balances and provides additional funds for eligible expenses.

When Healthcare Flexible Spending Account Ends

1. Your Healthcare FSA ends the same day your MPS Board paid health coverage ends. This is either on the last day of the month following the month in which you become ineligible due to non-payment of the required employee premium contribution, termination, suspension, resignation, layoff, move into a non-benefit eligible position, or unpaid status for more than one-half the number of paid work days in a calendar month. However, for Regular/Traditional and Early Start School Calendar employees who lose eligibility at the end of their regularly

scheduled school year, health coverage along with the Healthcare FSA, ends on August 31 following the loss of eligibility.

2. In the event you lose your FSA coverage due to a loss of employment for any reason (except gross misconduct), you may be eligible to elect Healthcare Reimbursement Account (HCRA) COBRA Continuation Coverage. In order to be eligible for HCRA COBRA Continuation Coverage, you must have elected COBRA Continuation Coverage under the applicable health plan, and must also have a positive balance in your reimbursement account as of the date of the qualifying event.

3. **FSA Card Usage After Termination:** Once the FSA vendor is notified of your termination date, you will not be able to use the card as the card will be inactivated and cannot be reissued. You will need to submit a Healthcare Claim Form in order to get reimbursed for your FSA balances.

DEPENDENT CARE FSA PROGRAM

The MPS Dependent Care FSA program is available for the 2024 Plan Year to all Active MPS employees. This plan allows you to set aside tax-free dollars to be used as reimbursement for work-related dependent care expenses you have already paid. Active employees who have dependent care expenses which enable them to be employed are eligible to enroll. If married, both you and your spouse must work unless your spouse is disabled or a full-time student while expenses are incurred. This plan operates on a calendar year basis with an annual open enrollment in October/November for the following calendar year. Once you enroll, the dollar amount that you determine will be deducted pre-tax from your gross earnings each paycheck and put into a "Dependent Care Account" for you. The Third-Party Administrator is P&A Group. Enrollment in the MPS Flexible Spending Account Program is done online through MPS Employee Self Service. **For more information about this plan, please see the Flexible Spending Account booklet on *mConnect* under Benefits Resources.**

How do you enroll for MPS Dependent Care FSA? See instructions in your new hire packet.

WHO QUALIFIES FOR THIS PROGRAM?

You qualify for this program if you are an active MPS employee (with the exception of Board members) and have dependent care expenses which enable you to be employed. If married, both you and your spouse must work unless your spouse is disabled or a full-time student while expenses are incurred.

PROGRAM HIGHLIGHTS

- You can contribute as little as $100 or up to $5,000 per family annually
- It is a completely Voluntary Program that you enroll in online to participate
- Your contribution is automatically deducted from your paycheck BEFORE TAXES
- Program Plan Year is from January 1 through December 31
- If you enroll during Open Enrollment, your Dependent Care FSA would begin on January 1, 2024
- For new employees hired mid-year, your Dependent Care enrollment is effective as of the first day of employment
- P&A Group is the Third-Party Administrator for Flexible Spending Accounts (FSA)
    - Website: www.padmin.com, Customer Service # 1-800-688-2611
- This is an **Internal Revenue Service (IRS) regulated program**, and there are certain rules you need to know and follow:
    - You need to make your annual election within 31 days of benefit eligibility or during the annual open enrollment period
    - You cannot transfer money between your HEALTHCARE and DEPENDENT CARE FSA accounts, even if the enrollment in a plan was in error
    - Claims can only be reimbursed for eligible work-related dependent care expenses you incur during the plan year

- Reimbursable costs are for the following Eligible Dependents:
  - Any child under the age of 13 who is claimed as a dependent on your tax return
  - Any other person claimed as a dependent on your tax return who is physically or mentally incapable of self-care and spends an average of 8 hours a day in your household
- You have 90 days after the plan year end of December 31st to submit expenses from the previous plan year for reimbursement

Keep in mind when planning FSA contributions – Estimate carefully since contributions that you do not use during the plan year for eligible expenses, you will lose (IRS regulations).

- Your child is in school half days during winter/spring semester; needs full-time care during summer and advances to full school days in the fall semester
- Your child reaches an age in day care where their weekly fee is slightly reduced
- Your child, a full-time student is available to watch the younger child(ren) during the summer
- Child(ren) go to grandparents for the summer
- Your child reaches age 13 during the year
- You and/or your spouse do not work because of vacation, holidays, or sick days
- Child(ren) are out of school for two weeks at Christmas and one week at Easter, however you have to work during those times
- Maximum contribution is $5,000 per family in a calendar year

When can I change my election or cease participation due to a change in family status and how do I do this online?
If you experience a mid-year qualified life event, you must notify MPS electronically via MPS Employee Self Service **within 31 days of the change or 60 days after the birth, adoption or placement for adoption.**

To make a change to your coverage due to a Family Status Change, go to the MPS homepage mpsmke.com, click the staff menu in the top blue bar and log in to Self Service. Then click the Benefit Details tile > Life Events tile > and make your selection from the list of life events and follow the instructions. Detailed instructions can be found on *mConnect* under Benefits Resources called Benefits Family Status Change- Self Service Instructions. Changes must be made within 31 calendar days of a qualifying family status change event, 60 calendar days for birth, adoption, or loss of Medicaid or State Children's Health Insurance Plan (CHIP).

MPS EMPLOYEE WELLNESS BENEFIT: HEALTHY YOU, HEALTHY SCHOOLS

Milwaukee Public Schools offers a robust employee wellness benefit for staff and their families. Our benefit includes a variety of programs and resources designed to improve your physical, emotional, and professional well-being. Programs include Wellness On-Site, Employee Assistance Program (EAP), UnitedHealthcare Tobacco Cessation program (for those enrolled in Unitedhealthcare insurance through MPS), and Healthy Contributions (gym reimbursement program).

Current employees may login to *mConnect* and visit the Employee Wellness page to learn more.

MILWAUKEE PUBLIC SCHOOLS

Employee Wellness Program

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

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

HEALTHY YOU
HEALTHY SCHOOLS
Professional | Physical | Emotional

Learn more about wellness programs on mConnect at mpsmke.com/wellness or under "Other Benefits" in this booklet. For additional information, email benefits@milwaukee.k12.wi.us.

Individual Program Offerings

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

- UHC programs include:
  - Real Appeal (Weight Loss Program)
  - Asthma Disease Management
  - Cancer Resources Services
  - Congenital Heart Disease Resource Services
  - Kidney Resource Services
  - Maternity Support Program
  - Diabetes Condition Management
  - Coronary Artery Disease
- Healthy Contributions Gym Reimbursement
- Employee Assistance Program

Group Program Offerings

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

- Healthy Cooking Demonstrations
- Heart Health
- Weight Loss
- Stress Management

See the Wellness Champion at your location! The Wellness Champion coordinates each worksite's involvement in the Wellness programs.

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

VIRTUAL VISITS

Connect to a doctor by phone or video through myuhc.com® or the UnitedHealthcare® app. Consider 24/7 Virtual Visits for these common conditions:

- **Allergies**
- **Bronchitis**
- **Eye infections**
- **Flu**
- **Headaches/migraines**
- **Rashes**
- **Sore throats**
- **Stomachaches**
- **And more!**

CONTRIBUTIONS GYM REIMBURSEMENT

Congratulations on taking a positive step toward wellness!

Milwaukee Public Schools is offering employees and their spouse a monetary reimbursement of $20.00 when you visit a participating fitness facility ten (10) or more times per calendar month.

In a continued effort to support your health and personal well-being, Milwaukee Public Schools is offering a reimbursement benefit at participating fitness facilities for employees and spouses. We are very excited to have you on board and look forward to offering you full access to a wealth of resources that are sure to enhance your work-life balance and yield remarkable results.

The following guidelines must be followed to receive the monetary incentive offered by Milwaukee Public Schools.

- Participants must be enrolled in the MPS health insurance plan to be eligible for his benefit.
- Participants must present a copy of the Milwaukee Public Schools Enrollment Form to the fitness facility to enroll in and participate in the program. Enrollment form can be found on mConnect/Departments/Benefits & Compensation/Employee Wellness/Gym Reimbursement: Healthy Contributions.
- Employees must provide the club upon enrollment their Employee ID. Spouses must provide the last four digits of their Social Security Number. If employees do not know their employee ID, please contact MPS HR 414-475-8224 or see your MPS employee paystub.
- Participant understands that facility locations are independently owned and operated and therefore can choose to participate in this program.

For a list of participating locations please visit www.healthycontributions.com and the club locator. Congratulations again!

Healthy Contributions
1.800.317-2739
info@healthycontributions.com
Monday- Friday, 8:00am to 5:00pm CST.

healthy CONTRIBUTIONS

healthy CONTRIBUTIONS

Wellness Certificate

MILWAUKEE PUBLIC SCHOOLS

This certificate entitles employees of Milwaukee Public Schools and their Spouses to a fitness reimbursement when enrolled at a participating fitness facility.

Get started today!

Complete the back of this page and bring this certificate to a participating facility.

Find a list of participating locations by visiting healthycontributions.com to find a location near you.

***Participant Name (First & Last): _____**

6 digit Employee ID/ last 4 digits of the Spouse's SSN#: _____

Milwaukee Public Schools Employees and Spouses:

- It is the bearer's responsibility to provide a method of payment to their fitness facility upon enrollment. Enrollment and key fees may be assessed by the club, in addition to membership dues.
- Reimbursements will be deposited to the employee's paycheck via the MPS pay schedule. Reimbursements will be added to the employee's second paycheck of every month.
- Transfer to another facility location requires notification to the new club this employee and spouse wellness benefit and a re-enrollment process will be imitated. Transfers are the sole responsibility of the member.
- Participants understand that facility locations are independently owned and operated and that membership guidelines may vary.
- Visit the Healthy Contributions page on mConnect to locate a club in the network. To nominate a facility, please use the nomination form on mConnect.
- Employee and Spouse must complete the back side of this certificate before enrolling with the facility. Please have the club make a copy for your records.

Toll Free 1.800.317.2739

info@HealthyContributions.com

HealthyContributions.com

CLUB OWNER OR OPERATOR ONLY:

Please read and understand the outlined terms.

- Please have the Milwaukee Public Schools Employee and Spouse complete the back of the certificate. Keep a copy of the signed portion for your records.
- To be a participant in this program, you must enroll with Healthy Contributions. Be sure to include the employee's 6 digit Employee ID and the last four digits of the spouse's SSN for tracking and payment fulfillment.

MILWAUKEE PUBLIC SCHOOLS

Gym Reimbursement Enrollment Form

Name:_____

Employee ID (6 digits):_____

Spouse SSN (last 4 digits): _____

Please log on to Employee Self Service and view any paycheck to find your employee ID number. Monthly reimbursements for eligible employees and spouses will be deposited into the employee's paycheck via the MPS pay schedule. Reimbursements will be added to the employee's second paycheck of every month.

- I understand the eligible employee and spouse must visit the participating fitness facility a minimum of ten (10) days per calendar month to receive a reimbursement and that one visit per day will be counted toward the monthly total.

- I understand that it is the eligible employee and spouse's responsibility to ensure that each of their visits is recorded at the fitness center.

- I understand that there will be approximately a one-month lag time between the time I complete the visits and the month I receive the reimbursement.

- Reimbursements, both employee AND spouse, will be added to the employee's paycheck. If both participants are employees, the reimbursement will be added to the check of the employee that is the primary insurance carrier with MPS.

- Reimbursements are taxed on each paycheck. Taxes are based only on your earned reimbursements! More information is available on the Healthy Contributions page on mConnect.

I understand the policies, procedures, and requirements of this program.

Signature:_____

Date: _____

Club Personnel: Please keep these records in a safe secure location. Do not fax, email, or mail them to Healthy Contributions. All information should be destroyed upon termination of membership.

healthy CONTRIBUTIONS

EMPLOYEE ASSISTANCE PROGRAM

The EAP is a free benefit provided to all employees of MPS, their spouses/partners, and their dependents. The EAP is 100% confidential as specified by both state and federal law. All employees and their families are provided free, confidential counseling and referral service pertaining to personal difficulties related to the following: Financial and legal consultation, medical advocacy, drug and alcohol abuse, childcare search, adoption assistance, school and college planning or eldercare assessment.

OTHER BENEFITS FOR ACTIVE EMPLOYEES

Tuition Reimbursement - The District is committed to promoting the professional growth of its employees. A tuition reimbursement policy will be offered to employees subject to limitations, including, but not limited to, that the courses: (1) relate to a reasonable promotional opportunity within the District; or (2) have direct impact that supports student learning and supports the needs of the District. Eligible employees must have completed two years of eligible service with the district, be in an active status, and scheduled 30 or more hours per week (employees on sabbatical or any paid or unpaid leave of absence are not eligible for tuition reimbursement.) Eligible employees must submit application for tuition reimbursement to the Office of Human Resources and obtain approval prior to the start date of the coursework or training. The availability of tuition reimbursement is subject to the approved District budget. Tuition reimbursement is subject to successful completion of coursework verified by the District. Details on the Tuition Reimbursement policy and application process can be found on *mConnect.* From the Home page select: Departments>Benefits, Pension & Compensation (under "Resources").

Note: Eligibility Restrictions for Tuition Reimbursement
> (3) Board Members are not eligible for tuition reimbursement.
> (15) Part-time Recreation Employees are not eligible for tuition reimbursement.
> (17) Active Substitute Teachers are not eligible for tuition reimbursement effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for tuition reimbursement.
> (22) Management Interns are not eligible for tuition reimbursement.
> (23) Supplemental Teachers are not eligible for tuition reimbursement.
> (24) Part-time Teachers are not eligible for tuition reimbursement.
> (25) Substitute Teachers Eligible for Benefits are not eligible for tuition reimbursement.

Liability Protection – The District covers employees for liability insurance for incidents arising in the performance of their duties that are within the scope of their employment in accordance with Wis. Stat. 93.35 and 895.46 as amended. Employees are required to promptly report any formal claims or legal service to their supervisor and the MPS Office of Finance, Department of Procurement and Risk Management to fully cooperate with the District in the defense and investigation of such incidents and claims.

Prescription Safety Glasses
Prescription safety glasses are offered once per year (with a new prescription) and replaced as needed if damaged, stolen, or lost.

Note: Only the following units are eligible for Prescription Safety Glasses
> (5) Building Engineers unit
> (6) Building Service Helpers unit
> (7) Building Trades unit
> Some employees in units listed under (21) that are required to wear safety glasses (see Introduction on page 3 for a list of these employee groups). Please check with your supervisor to confirm if you are eligible for this benefit.

LIFE INSURANCE

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life and Accidental Death and Dismemberment Insurance is an employer-paid benefit and coverage begins first day of the month that follows or coincides with 30 consecutive days of eligibility. MPS employees regularly scheduled to work in benefit-eligible positions of 30 or more hours per week will be automatically enrolled for this benefit.

The amount of Group Basic Life coverage is one times your annual earnings, rounded up to the next $1,000, to a maximum of $200,000.

Please note that the value of the premium payment in excess of a $50,000 benefit coverage level is subject to federal income tax when the Board pays 100% of coverage in excess of $50,000.

If you remain an active employee at attainment of age 65, your active life insurance coverage will reduce in the following manner:

Age of Employee on Jan 1st:	Coverage in force prior to age 65 is reduced to:
65 through 69	65%
70 through 74	50%
75 or over	35%

Notice of Conversion and Portability of Insurance Rights: Under the provisions of the Group Basic Life Insurance plan, you may be entitled to convert or purchase portable group insurance coverage within 31 calendar days of the date your group coverage ends, to an individual policy without evidence of insurability. The Standard Insurance Company, upon your request, will furnish information about individual policies that may be available.

Additional Life Insurance

Employees regularly scheduled to work in benefit-eligible positions of 30 or more hours per week can elect Additional Life Insurance for self, spouse, and/or child(ren) within 31 days of your date of benefit eligibility. Enrollment and beneficiary designation for this benefit is done online through the Standard Insurance Company's website standard.benselect.com.

Premiums are employee-paid through a monthly payroll deduction. If elected, coverage begins first day of the month that follows or coincides with 30 consecutive days of eligibility. Below are the coverage amount guidelines:

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

*Not to exceed 5 times your annual earnings.

Please note:

- Additional Life Insurance must be elected for yourself in order to elect coverage for dependents.
- The coverage amount for your spouse and child(ren) cannot exceed 50% of your Additional Life coverage.
- The age reductions in the chart above apply to Additional Life Insurance.
- Beneficiary designation(s) can be changed at any time at standard.benselect.com.
- Late applications for Additional Life Insurance (applying 31 days after first initial eligibility): All late applications, requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- Family Status Change: If you have a Family Status Change, you may elect new coverage or increase your coverage for you or your spouse, not to exceed the Guarantee Issue Amount, without submitting Evidence of Insurability if you apply within 31 days of a Family Status Change (see Family Status Changes/Life Events chart in the Health & Dental Plans for Active Employees booklet on *mConnect*).

- Coverage ends automatically on the earliest of:
  - The date the last period ends for which a premium was paid for your Life Insurance;
  - The date the Group Policy terminates;
  - The end of the calendar month in which your employment terminates, unless you are covered as a retired Member; see life insurance certificate in Benefit Resources under *mConnect*.

Note: Eligibility Restrictions for Life Insurance
> (3) Board Members are not eligible for life insurance benefits.
> (15) Part-time Recreation Employees are not eligible for life insurance benefits.
> (17) Active Substitute Teachers are not eligible for life insurance benefits effective 9/1/12.
> (20) Temporary Employees, LTEs are not eligible for life insurance benefits.
> Seasonal Laborers are not eligible for life insurance benefits effective with dates of hire or layoff on or after 7/1/12.
> Full-time members of the armed forces are not eligible for life insurance benefits.
> A leased employee or an independent contractor are not eligible for life insurance benefits.
> (23) Supplemental Teachers, (24) Part- time Teachers, and (25) Sub Teachers on Special Assignment are not eligible for life insurance benefits.

DISABILITY INSURANCE

Short Term Disability

Short Term Disability (STD) is a voluntary plan available to employees regularly scheduled to work in a benefit-eligible position of 30 or more hours per week. STD pays a weekly benefit in the event you cannot work because of a covered illness or injury. A STD benefit replaces a portion of your weekly income, providing funds directly to you to help pay your bills and living expenses. Premiums are employee-paid through a monthly payroll deduction.

The weekly STD benefit is 66 2/3 percent of the first $5,769 of your weekly insured predisability earnings, reduced by deductible income. Upon initiation of STD Benefits, you will not be able to receive any paid leave (except vacation pay) from Milwaukee Public Schools. As a result, employees should be taking unpaid leave when electing to initiate STD benefits.

The maximum benefit period is as follows:

- 90 days for (2) Exempt Administrators and Supervisors, (8) Cabinet Level, (13) Office of Accountability and Efficiency, (14) Office of Board Governance and the (18) Superintendent.
- 180 days for all other eligible employee units.

Enrollment for this benefit is done online through The Standard Insurance Company's website standard.benselect.com. Benefit-eligible employees can elect the STD coverage within 31 days of becoming eligible and coverage begins the first day of the month that follows or coincides with 30 consecutive days of eligibility.

Elections made after the 31-day eligibility period will be subject to a 60-day benefit waiting period.

Late application for Short Term Disability: If you do not apply for this STD coverage within 31 days of first becoming eligible, were eligible for insurance under the Prior Plan for more than 31 days but were not insured, or if your insurance ends because you failed to make a required premium contribution and is later reinstated, your benefit waiting period for physical disease, pregnancy or mental disorder will be 60 days if you become disabled during the first 12 months after your coverage takes effect.

- **Example of how the Late Enrollment Benefit Waiting Period Penalty applies:** Let's assume you elect STD as a late applicant and your coverage becomes effective 2/1/2024. If you file a claim for a disability occurring between 2/1/2024 – 1/31/2025 instead of a normal 7 calendar day benefit waiting period, you will instead have a 60 calendar day benefit waiting period from the date of disability. Essentially, for any disability occurring prior to 2/1/2025 (other than a disability caused by an accident, which remains a zero-day benefit waiting period regardless) you will wait 60 calendar days from the date of disability until STD benefits become payable. This assumes the claim is approved and you are still within a recovery period (which will all be reviewed and determined at the time of a claim). After 12 months have passed following your enrollment into the STD

coverage, your benefit waiting period will then return to 7 calendar days and you will no longer be subject to the penalty as long as you maintained continuous STD coverage throughout those 12 months prior.

- **Maternity as a late entrant into STD Insurance**: Please note: The below are typical scenarios. If complications arise in pregnancy or birth, this can alter the date of disability and expected recovery period.
    - Let's again assume you elect the STD as a late applicant and your coverage becomes effective 2/1/2024. If you give birth prior to 2/1/2025, you will have a 60 calendar day benefit waiting period from the date of disability (which is typically the date you give birth or the date your physician recommends you cease work). A normal recovery period following birth is 6 weeks (or 42 days), which is less than the 60 day benefit waiting period. In this scenario, you would be recovered from birth before any STD benefits become payable. If you give birth after 1/31/2025, your 60 day benefit waiting period penalty ends and you return to a 7 calendar day benefit waiting period as long as you maintained continuous STD coverage throughout those 12 months prior.

Long Term Disability

Long Term Disability (LTD) is a voluntary plan available to employees regularly scheduled to work in a benefit-eligible position of 30 or more hours per week. LTD pays a monthly benefit in the event you cannot work because of a covered illness or injury. A LTD benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need. Premiums are employee-paid through a monthly payroll deduction.

Late application for Long Term Disability: All late applications (applying 31 days after becoming eligible), requests for coverage increases, and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior LTD insurance plan are also subject to medical underwriting approval.

There are two options for enrollment:

LTD Option #1	***LTD Option #2***
Benefit Amount: 66 2/3% Income Replacement *Maximum Monthly Benefit: $16,667 per month maximum* *Maximum Benefit Period: Normal Social Security Retirement Age*	*Benefit Amount: 60% Income Replacement* *Maximum Monthly Benefit: $16,667 per month maximum* *Maximum Benefit Period: 5 Years* **Cost of Living is not included in this option*

The benefit waiting period is as follows:

- 90 days for (2) Exempt Administrators and Supervisors, (8) Cabinet Level, (13) Office of Accountability and Efficiency, (14) Office of Board Governance and the (18) Superintendent.
- 180 days for all other eligible employee units.

Enrollment for this benefit is done online through The Standard Insurance Company's website standard.benselect.com. Benefit-eligible employees can elect the LTD coverage within 31 days of becoming eligible and coverage begins the first day of the month that follows or coincides with 30 consecutive days of eligibility.

Note: Eligibility Restrictions for Disability Insurance:
> (3) Board Members are not eligible for disability insurance.
> (15) Part-time Recreation Employees are not eligible for disability insurance.
> (17) Active Substitute Teachers are not eligible for disability insurance.
> (20) Temporary Employees, LTEs are not eligible for disability insurance.
> Seasonal Laborers, full-time members of the armed forces, leased employees and independent contractors are not eligible for disability insurance.
> (23) Supplemental Teachers are not eligible for disability insurance.
> (24) Part-time Teachers are not eligible for disability insurance.
> (25) Substitute Teachers Eligible for Benefits are not eligible for disability insurance.

RETIREMENT SAVINGS PLANS AND PENSION PLANS FOR ACTIVE EMPLOYEES

Milwaukee Public Schools 403(b) Plan

This voluntary retirement savings plan, also referred to as a tax-deferred annuity plan, is available to all eligible MPS employees. Similar to a 401(k) plan, the 403(b) plan allows you to make voluntary before-tax and Roth contributions from your salary via payroll deduction.

Employees are solely responsible for investigating investment risks and selecting the tax annuity/mutual fund options of individual account(s). See the approved vendors list for authorized investment providers for the MPS 403(b) Plan on the next below. Employees may contact representatives from the approved vendors list to discuss and review investment options. There is no charge for this service.

- To begin contributing into the MPS 403(b) Plan:
  - Contact the MPS approved investment provider to establish an account; and
  - Complete a required Salary Reduction Agreement. Allow one to two payroll cycles for contributions to be taken through payroll deductions after submitting a Salary Reduction Agreement.
- To cancel payroll deductions to the MPS 403(b) Plan at any time:
  - Contact the MPS approved investment provider to request the cancellation of payrolll deductions; and
  - Complete a required Salary Reduction Agreement. Payroll deductions will be cancelled as soon as administratively possible.

For the IRS annual limit regarding 403(b) plans, please reference the Internal Revenue Services Retirement Topics – 403(b) Contribution Limits website at: https://www.irs.gov/retirement-plans/plan-participant-employee/retirement-topics-403b-contribution-limits.

Note: Eligibility Restrictions for 403(b) Plan
> (3) Board Members are not eligible for this 403(b) Plan benefit.

LIST OF APPROVED VENDORS FOR THE MILWAUKEE PUBLIC SCHOOLS 403(b) PLAN

Voya Life Insurance and Annuity Company Local Representative Team: 414-256-2187 Voya Customer Service: 800-684-5001 https://milwaukee.beready2retire.com/	**TIAA-CREF** National Contact Center: 800-842-2273 Enrollment Hotline: 800-842-2888 https://www.tiaa.org/public/tcm/mps
WEA TSA Trust Hotline: 800-279-4030 or 414-259-1990 https://www.weabenefits.com/	**MetLife** Local Representative Team: 414-615-4926 www.metlife.com/mps

(Important: Only the investment providers indicated on the above List of Approved Vendors are eligible to receive employee contributions (payroll deductions) under the Milwaukee Public Schools 403(b) Plan.)

Planwithease.com is a third-party plan administrator that MPS has selected to administer the 403(b) Plan. You can go to http://www.planwithease.com to view a summary of your account with your investment provider, access financial education information, or use the tools and calculators to help you plan for your retirement. On the behalf of MPS, Planwithease.com also authorizes loan approvals, withdrawals, contract exchanges, and rollover transaction requests under the Plan. For questions, contact Planwithease.com at 855-446-6928.

457 Program

All eligible employees can enroll in the Wisconsin Deferred Compensation 457 Program (WDC). Under this Program you are eligible to make voluntary before-tax and Roth contributions. The IRS annual contribution limits for this program are in addition to (not offset by) the 403(b) IRS annual contribution limit. The WDC 457 Program is administered by and funds are held in trust by the State of Wisconsin - Employee Trust Funds (ETF). Empower Retirement is the ETF appointed service provider for the WDC 457 Program. To learn more about the Deferred Compensation program, contact WDC at

877-457-9327 or their website www.wdc457.org. To enroll directly with Milwaukee Public Schools, contact the MPS Pension Office at 414-475-8730 or MPSPension@milwaukee.k12.wi.us to obtain the enrollment code.

Employee Trust Funds (ETF) (Wisconsin Retirement System (WRS))

- Eligible Certificated employees hired prior to January 1, 2024 are enrolled in the ETF
- All Eligible Employees (Certificated and Classified) hired after January 1, 2024 will be enrolled with ETF

All employees eligible for enrollment in the Employee Trust Funds (Wisconsin Retirement System) are required to pay 6.9% employee contribution on a before-tax basis for 2024. The required employee contribution is subject to change prospectively as determined by the Wisconsin Retirement System on a calendar year basis.

In accordance with the Employee Trust Funds Benefit Handbook, vesting rules are as follows:

- If WRS employment began after 1989 and employment terminated before April 24, 1998, then the employee must have some WRS-credible service in 5 calendar years.
- If WRS employment began on or after July 1, 2011, then the employee must have five years of WRS-credible service.
- If neither vesting requirement applies, the employee is considered vested when the employee first began WRS employment.

Contact Employee Trust Funds at 877-533-5020 for more information.

Note: Eligibility Restrictions for WRS Pension
> This benefit applies only to eligible Employees.
> (3) Board Members are not eligible for this pension benefit.
> (15) Part-time Recreation Employees are not eligible for this pension benefit unless enrolled in WRS in a primary job.
> (20) Temporary Employees, LTEs are not eligible for pension benefit.

City of Milwaukee Employes' Retirement System (ERS)

- Classified Employees hired prior to January 1, 2024 are enrolled with the City of Milwaukee Employees' Retirement System **(This Plan is closed to new hires as of December 31, 2023)**

Eligible employees are enrolled in the City of Milwaukee – Employees' Retirement System (ERS) in accordance with the charter ordinance and applicable ERS rules.

- Effective July 1, 2012, all employees enrolled in the City of Milwaukee Employees' Retirement System (ERS) and who were hired prior to January 1, 2014 will pay 5.5% employee contribution on a before tax basis. As an ERS Member, you earn vesting rights after completing four credible years of service.
- **Effective with dates of hire on or after January 1, 2014 to December 31, 2023**, employees enrolled in the City of Milwaukee Employees' System will pay 4.0% employee contribution on a before tax basis. As an ERS Member, you earn vesting rights after completing four credible years of service.
- MPS Classified employees hired on or after October 22, 2012 shall be enrolled as members in accordance with the charter ordinance and applicable ERS rules if one of the following events occur: if the person is employed in a position regularly scheduled for 30 hours or more per week on either a 10 or 12-month basis, you are employed as a 12-month employee on a yearly basis and work more than 1,040 hours in a calendar year, or you are employed as a 10-month employee on a yearly basis and work more than 800 hours in a calendar year.

Contact City of Milwaukee Employees' Retirement System at 414-286-3557 for more information.

Note: Eligibility Restrictions for City ERS Pension
> This benefit applies only to eligible Classified Employees who work 30 or more hours.
> (3) Board Members are not eligible for this pension benefit
> (15) Part-time Recreation Employees are not eligible for this pension benefit.
> (20) Temporary Employees, LTEs are not eligible for this pension benefit.
> (22) Management Interns are not eligible for pension benefits unless they had an active ERS pension before the start date of their Management Intern position.

MBSD Supplemental Early Retirement Plan for Teachers

This Plan offers a supplemental pension benefit for teachers hired prior to July 1, 2013 that meet eligibility and vesting requirements as defined in the Plan Document. The Plan is closed to employees in the Teachers unit who are hired, rehired or transferred or demoted to the Teachers unit on or after July 1, 2013. The Plan was frozen as of July 1, 2013. This means that for purpose of calculating benefits, compensation and service credit up to July 1, 2013 as a teacher will be used.

This Plan is administered by the Pension Office of the MPS Department of Benefits, Pension & Compensation in the Office of Human Resources. Contact the Pension Office at 414-475-8730 for more information.

Note: Eligibility Restrictions for MBSD Supplemental Early Retirement Plan for Teachers
>This is a closed and frozen plan with eligibility restricted to the Teachers Unit as defined in the Plan Document.

MBSD Early Retirement Supplement and Benefit Improvement Plan

This Plan offers a supplemental pension benefit for certificated administrators and supervisors including exempts hired prior to July 1, 2003 that meet the eligibility and vesting requirements as defined in the Plan Document. A temporary benefit is provided to certain classified administrators and supervisors including exempts that meet the eligibility requirements as defined in the Plan Document. The Plan was closed on July 1, 2003 and only covers those individuals who were Covered Employees on or before June 30, 2003 in accordance with the Plan Document.

This Plan is administered by the Pension Office of the MPS Department of Benefits, Pension & Compensation in the Office of Human Resources. Contact the Pension Office at 414-475-8730 for more information.

Note: Eligibility Restrictions for MBSD Early Retirement Supplement and Benefit Improvement Plan>This is a closed plan with eligibility restricted to certificated administrators and supervisors and certain classified employees as defined in the Plan Document.

REHIRED RETIREE BENEFITS

Eligibility for Rehired Retiree Benefits

Under a district-wide provision effective July 1, 2013, all MPS retirees who are enrolled in MPS retiree medical and life insurance benefits will not lose eligibility for such retiree benefits by being rehired in MPS benefit-eligible positions. However, they will not be eligible to enroll in active medical and life insurance benefits unless they submit an irrevocable signed waiver of their MPS retiree medical and life insurance benefits. An MPS retiree who signs an irrevocable waiver of their previously earned MPS retiree medical and life insurance acknowledges that he/she (a) permanently and irrevocably forfeits their previously earned eligibility for themselves and their enrolled dependents for retiree medical and life insurance benefits and (b) is eligible to enroll in active MPS medical and life insurance benefits. A rehired retiree that keeps his/her retiree medical and life insurance is eligible to enroll in active dental coverage within 31 days of rehire in a benefit- eligible position.

Rehired Wisconsin Retirement System (WRS) Annuitants

For employees who terminate before July 1, 2013**:** A WRS participant who has applied to receive a retirement annuity ***must wait at least 30 days between terminating covered employment with a WRS employer and returning as a participating employee.*** If the employee does not wait the 30-day period, and is rehired before the expiration of the 30-day period, the employee is not eligible to receive a WRS retirement annuity. The rehired annuitant who has fulfilled the requirements and meets the eligibility criteria under the WRS may choose to either return to active participation in the WRS or continue their WRS annuity and must complete a WRS Rehired Annuitant Election Form.

For employees who terminate on or after July 1, 2013: A WRS annuitant ***must remain separated from employment with a WRS participating employer for at least 75 days*** in order to be an eligible rehired annuitant. If a WRS annuitant, or disability annuitant who has attained his or her normal retirement date, is appointed to a position with a WRS-participating employer, in which he or she is expected to work at least two-thirds of what is considered full-time employment by ETF, the annuity must be terminated and no annuity payment is payable until after the participant again terminates covered employment. These provisions first apply to a WRS participating employee who terminates on or after July 1, 2013.

BENEFITS INFORMATION FOR EMPLOYEES ON LEAVE OF ABSENCE

Unpaid Leave of Absence - (Except Family Medical Leaves (FMLA) – see FMLA section on page 31.)
If you are on an unpaid leave of absence which includes suspension, your benefits will be administered as follows:

Health/Vision and Dental Coverage: Board paid coverage ceases on the last day of the month following the month in which your unpaid status is effective.

For example, if your unpaid leave of absence is effective on November 25th, your Board paid coverage will remain in effect until December 31st and you will be billed for coverage starting January 1st. If your unpaid leave of absence is effective on December 4th, Board paid coverage will remain in effect until January 31st and you will be billed for coverage starting February 1st.

However, for 10-month employees who go on unpaid status after the end of the school year or at the start of the next school year, Board paid coverage ceases August 31st.

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

Group Basic Life Insurance and Additional Life Insurance Coverage: Board paid Life Insurance and Additional Life Insurance coverage (if applicable) terminates at the end of the month in which your unpaid leave of absence begins. You will be billed for coverage starting the following month.

Short Term Disability and Long Term Disability (Employee paid benefits): If you are on an unpaid leave of absence (non-health related) and enrolled in Short Term Disability (STD) and/or Long Term Disability (LTD), your STD and/or LTD will be terminated as of your leave of absence date. If you are on an unpaid leave of absence that is health-related, you will be billed for coverage starting the following month.

Self-Pay Option
Once your Board paid coverage has ended as outlined above, you have the option of continuing your coverage by self-paying the entire premium amount. Please note that health and/or dental coverage extended under the leave provision is automatically deemed to be continuation coverage under COBRA.

Per COBRA guidelines, the plan is not required to send monthly premium notices for self-pay benefits. Please contact us if there is any question regarding what you owe. If you choose not to self-pay for your coverage, your coverage will end the first month you are billed as described above. MPS Department of Benefits, Pension & Compensation will initially bill you for amounts owed. If you do not receive a bill within 3 weeks of your coverage ending, please contact us at the following numbers:

If your LAST NAME begins with A-F call: 414-475-8158	If your LAST NAME begins with M-R call: 414-475-8215
If your LAST NAME begins with G-L call: 414-475-8233	If your LAST NAME begins with S-Z call: 414-475-8559
Life Insurance and Short/Long Term Disability call: 414-475-8699	

If you elect to exercise this self-pay option, any such period of self-paid coverage will be deemed to be an election to exercise COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage. Per COBRA guidelines, the plan is not required to send monthly premium notices; please contact us if there is any question regarding what you owe.

If you choose, you may switch to single coverage at any time while on unpaid leave of absence. However, you cannot re-enroll in a family plan until the next available open enrollment period. Your application to switch to single coverage must be received by MPS Department of Benefits, Pension & Compensation prior to the effective date requested. For example, if you would like to switch to single medical coverage effective November 1st, your application to change to single must be received by us by October 31st. Timely receipt of your application for the effective date requested still applies whether or not you are in receipt of a billing statement.

Return from Unpaid Leave of Absence

If you do not continue your benefits while on an unpaid leave of absence by self-paying the applicable premium, your medical/vision and dental insurance will remain terminated until you return to work and you must re-enroll for coverage as explained below. Your effective date of coverage is subject to the same eligibility rules that apply to a new employee. **Your health/vision and dental coverage are NOT automatically reinstated if your policy lapses due to non-payment.** You must submit a completed enrollment form within 31 calendar days of your return to work or you must wait until the next open enrollment period (currently scheduled for October/November with coverage effective January 1st) to enroll. **This form can be found under mConnect > Resources > Benefits Resources > Benefits Application/Change Form.**

For example, if you return to work on April 18th and submit a completed enrollment form to MPS Department of Benefits, Pension & Compensation within 31 calendar days, your dental/health/vision coverage is effective June 1st. If you return to work on April 18th but do not submit a completed enrollment form within 31 calendar days, you must wait until the next open enrollment period to enroll.

If you continue your benefits by self-paying for coverage while on unpaid leave of absence, you will not need to reapply upon your return to work. However, Board paid health/vision and dental will not resume until after the applicable waiting periods as described above. You must continue to self-pay throughout the waiting periods until Board paid coverage resumes in order to have continuous coverage.

Group Basic Life Insurance coverage, if applicable, is reinstated automatically upon your return to work within 90 days. If you are returning to work after 90 days, your life insurance will begin the first day of the month that follows or coincides with 30 consecutive days.

Short Term Disability, Long Term Disability and Additional Life Insurance coverage are reinstated if you return to work within 90 days. If you return from leave after 90 days your coverage will not be reinstated. You can reapply for these benefits at standard.benselect.com and if approved, coverage will begin the first day of the month that follows or coincides with 30 consecutive days of your return from leave. Evidence of Insurability may apply.

Paid Leave of Absence

Health/Vision, Dental, Group Basic Life Insurance, Short Term Disability, Long Term Disability and Additional Life Insurance Coverage: If you qualify and are granted a paid leave of absence your Board paid health/vision, dental, and life insurance coverage will continue as long as you are on the paid leave of absence. If you are enrolled in Short Term Disability, Long Term Disability and/or Additional Life Insurance, your coverage will also continue as long as you are on a paid leave of absence and premium contributions are deducted from your paycheck, when applicable.

Upon your **return to work from a paid leave of absence** to a benefit-eligible position you do not need to reapply for health/vision, dental, life insurance, Short Term Disability, Long Term Disability and/or Additional Life Insurance coverage, if your premiums were paid, when applicable.

Family Medical Leave (FMLA)

Health/Vision and Dental Coverage: If you qualify and are granted a leave under the FMLA, your Board paid health/vision and dental coverage will continue as long as you are on FMLA. NOTE: You are still required to pay your employee premium contribution. If you take a paid FMLA, premium contributions will be deducted as usual from your paycheck. **If your FMLA is unpaid, your missed employee premium contribution will be put into arrears, and these deductions will be applied in full to your first paycheck upon return to work from your approved leave or billed to you in full if you do not return to work at the District at the end of your unpaid FMLA leave.**

If you exhaust your FMLA and continue on an unpaid leave of absence, please refer to the **Unpaid Leave of Absence** section above for information on how this will affect your benefits.

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

Group Basic Life Insurance Coverage: If you are on a paid Family Medical Leave your Life Insurance will continue. Your Board paid Life Insurance coverage is terminated at the end of the month you begin your unpaid FMLA Leave. Once your Board paid coverage has ended, you have the option of continuing your Life Insurance coverage by self-paying the entire premium amount. If you choose not to self-pay for your coverage, you will not have coverage as of the first month you are billed. MPS Department of Benefits, Pension & Compensation will initially bill you for amounts owed.

Voluntary Benefits Billing- Short Term Disability, Long Term Disability and Additional Life Insurance: If your FMLA is unpaid and you are enrolled in voluntary Short Term Disability (STD), Long Term Disability (LTD) and/or Additional Life Insurance, MPS Department of Benefits, Pension & Compensation will bill you for the amount owed and you can continue the coverage by self-paying the entire premium amount. These benefits terminate at the end of the month in which your unpaid leave of absence begins. If you choose not to self-pay for your coverage, you will not have coverage as of the first month you are billed. If your FMLA is paid, your STD, LTD and/or Additional Life Insurance will continue, as premium contributions will be deducted from your paycheck when applicable.

Healthcare Flexible Spending Account (FSA)

If you are on an unpaid leave of absence and your MPS health insurance coverage ends, your Healthcare FSA will end the same day. This is either on the last day of the month following the month in which you become ineligible due to non-payment of the required employee premium contribution, termination, suspension, resignation, layoff, move into a non-benefit eligible position, or unpaid status for more than one-half the number of paid work days in a calendar month. However, for Regular/Traditional and Early Start School Calendar employees who lose eligibility at the end of their regularly scheduled school year, health coverage along with the Healthcare FSA, ends on August 31 following the loss of eligibility.

In the event you lose your FSA coverage, you may be eligible to elect Healthcare Reimbursement Account (HCRA) COBRA Continuation Coverage. In order to be eligible for HCRA COBRA Continuation Coverage, you must have elected COBRA Continuation Coverage under the applicable health plan, and must also have a positive balance in your reimbursement account as of the date of the qualifying event.

FSA Card Usage After Termination of FSA: Once P&A Group is notified of the termination of your account your card will be deactivated. To process claims for service P&A Group customer service at 1-800-688-2611.

Upon your return to work from a leave of absence and your re-enrollment in either the MPS EPO or PPO health insurance plan, you may be eligible to elect a Healthcare FSA within 31 days of your return from leave or 60 days after the birth, adoption, or placement for adoption. See Return from Unpaid Leave of Absence on the previous page.

Family Status Change

If you experience a Family Status Change while on any Leave of Absence, and you are continuing your health/vision and/or dental insurance and wish to make a change to your coverage, (i.e., adding a newborn) you are required to notify MPS Department of Benefits, Pension & Compensation within 31 calendar days (60 days for birth, adoption or loss of Medicaid or State Children's Health Insurance Plan (CHIPS)) of the Family Status Change. A Family Status Change is defined as marriage, birth, adoption, divorce, death, or an involuntary change in other insurance coverage.

To make a change to your coverage due to a Family Status Change, go to the MPS homepage mpsmke.com, click the staff menu in the top blue bar and log in to Self Service. Then click the Benefit Details tile > Life Events tile > and make your selection from the list of life events and follow the instructions. Detailed instructions can be found on *mConnect* under Benefits Resources called Benefits Family Status Change- Self Service Instructions. Changes must be made within 31 calendar days of a qualifying family status change event, 60 calendar days for birth, adoption, or loss of Medicaid or State Children's Health Insurance Plan (CHIP).

MANDATORY NOTICES

General Notice of COBRA Continuation Coverage Rights

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

Introduction

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

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

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

This notice provides important information about your COBRA continuation coverage rights. Continuation coverage periods are specified for qualifying events for each person ("qualified beneficiary") entitled to elect COBRA continuation coverage for 18 or up to 36 months depending on the qualifying event. For more details, see section entitled "How long will continuation coverage last?" If you elect to exercise any rights to self-pay your coverage at the active employee rate while on an approved leave of absence (other than leave under state or federal Family and Medical Leave Acts), any such period of self-paid coverage will be deemed to be an election of COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage. Qualified beneficiaries include:

- Employee or former employee
- Spouse or former spouse of employee
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. 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. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

What is COBRA Continuation Coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include

the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including Open Enrollment and special enrollment rights.

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct (MPS reserves the right to deny continuation coverage to you and your qualified beneficiaries under COBRA if MPS determines that the circumstances leading to termination of your employment establish gross misconduct.)

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the

employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

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

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

How long will continuation coverage last?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. If you elect to exercise any rights to self-pay your coverage at the active employee rate while on an approved leave of absence (other than leave under state or federal Family and Medical Leave Acts), any such period of self-paid coverage will be deemed to be an election of COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage.

In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Milwaukee Public Schools, Department of Benefits, Pension & Compensation of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

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

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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

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

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed in your election notice. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

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

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments shall be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the last day of the previous month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

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

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

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

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes
In order to protect your rights and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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

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

Mandatory Social Security Number Reporting Requirement

A Federal law has been passed (Section 111 of Public Law 111-173) that requires you to provide you and your covered dependent's Social Security Numbers ("SSN") to your group health plan. As a covered participant of a group health plan, your SSN will likely be requested in order to meet the requirements of P.L. 110-173 if this information is not already on file with your group health plan. Your SSN will be reported to Medicare so that a determination can be made of which plan is to pay primary when dual coverage exists with Medicare. If you do not provide your and your dependent's SSN, your Employer may face a substantial penalty for non-compliance. If you have any questions about this reporting requirement, please contact the Office of Human Resources, Department of Benefits, Pension & Compensation at 414-475-8217.

Newborns' and Mothers' Health Protection Act of 1996

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

Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

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

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

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

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

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

Notice of Creditable Coverage - Important Notice from Milwaukee Public Schools
PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

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

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

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

b. You can maintain your MPS health insurance coverage and enroll/pay for a Medicare prescription drug plan. You will still be eligible to receive MPS health insurance plan benefits

which cover other health insurance expenses in addition to prescription drug coverage. However, you have to pay the Medicare prescription drug plan premium.

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

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Milwaukee Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact OptumRx at 1-877-440-5982. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MPS changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/01/2023
Name of Entity/Sender: MILWAUKEE PUBLIC SCHOOLS
Contact—Position/Office: Department of Benefits, Pension & Compensation
Address: P.O. Box 2181, Milwaukee, WI 53201-2181
Phone Number: (414)475-8441

Notice of Privacy Practices

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

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

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

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

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

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

OUR USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

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

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

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

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

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

- **You and Your Authorization:** We must disclose your health information to you, as described below in Your Rights section of this notice. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your health information for any reason except those described in this notice. The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes if recorded by us; (ii) uses and disclosures of health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of health information; and (iv) other uses and disclosures not described in this Notice.
- **Your Family and Friends:** We may disclose to a family member, a friend, or other persons you indicate are involved in your care or payment for your care, your health information that is directly relevant to their involvement. We may use or disclose your name, location, and general condition or death to notify or help with notification of a family member, your personal representative, or other persons involved in your care about your situation. If you are present, we will give you the opportunity to object before we disclose your health information to these persons. If you are incapacitated or in an emergency, we may disclose your health information to these persons if we determine that the disclosure is in your best interest.
- **Underwriting:** We may receive your health information for premium rating or other activities relating to the creation, renewal or replacement of a contract of health or dental insurance or health or dental benefits. We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.
- **Disaster Relief:** We may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.
- **Death, Organ Donation:** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **Public Health and Safety:** We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your health information to a government agency authorized to oversee the health care system or government programs or its contractors and to public health authorities for public health purposes. We may disclose your health

information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes.

- **Plan Sponsor**: We may disclose your protected health information to the Milwaukee Board of School Directors as plan sponsor to carry out plan administration functions that it performs upon certification by the plan sponsor that it has adopted provision to appropriately protect health information. We may disclose summary information about the members of the PPO Health Plan, Exclusive Provider Organization (EPO) Health Plan, High Deductible Health Plan (HDHP), Self-Insured Indemnity (PPO) Dental Plan and the Delta Dental EPO Dental Plan for the plan sponsor to use to obtain premium and cost information, or to decide whether to seek modifications of the PPO Health Plan, EPO Health Plan, HDHP, Self Insured Indemnity (PPO) Dental Plan and the Delta Dental EPO Dental Plan. We may also disclose eligibility, enrollment and disenrollment information to the Plan sponsor.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law. For example, we must disclose your health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings:** We may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.
- **Law Enforcement:** Under circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your health information to law enforcement officials. We may disclose limited health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security:** We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

- **Access:** You have the right to review or obtain copies of your health information in our possession, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.25 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.
- **Disclosure Accounting:** You have the right to receive an accounting of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information, (i) made prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- **Restriction Requests:** You have the right to ask to restrict our uses and disclosures of your health information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or others who are involved in your health care or payment for your health care. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We are also required to agree to a request to restrict disclosure of your health information to a health plan if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the health information pertains solely to a health care item or service for which you or a person other than

the health plan on your behalf, had paid in full. Any request to restrict must be made in writing and should identify (i) the information to be restricted; (ii) the type of restriction being requested (for example, the use or disclosure, or both), and (iii) to whom the limits should apply.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your health information by alternative means or to an alternative location. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Electronic Notice:** If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.
- **Notification of Breach:** We are required to notify you of any breach of your unsecured protected health information.

QUESTIONS AND COMPLAINTS

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

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

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

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

Patient Protection Disclosure

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

Plan Status: Non-Grandfathered Plan

Your MPS plan is classified as Non-Grandfathered.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in the following state you may be eligible for assistance paying your employer health plan premiums. The following information is current as of July 31, 2023. Contact your State for more information on eligibility -

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

Notice of Special Enrollment Rights

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

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

Special enrollment rights also may exist in the following circumstances:

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

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments.
To request special enrollment or obtain more information, contact the Office of Human Resources, Department of Benefits, Pension & Compensation at 414-475-8217.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What Is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Department of Benefits, Pension & Compensation at 414-475-8554. For more information regarding the Marketplace please call 1-800-318-2596.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

- As your employer, we offer a health plan to:
  - □ All employees.
  - ☑ Some employees. Eligible employees are: Employees regularly scheduled to work in benefit eligible positions of 30 hours or more per week.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: The following individuals who meet specific eligibility requirements include spouse, dependent child, grandchild, legal ward. For more information, visit mpsmke.com > Careers > Resources > Employee Benefits Summary.
  - □ We do not offer coverage.

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

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

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

Summary of Benefits and Coverage

In accordance with the requirements of the Affordable Care Act ("ACA" also known as the health care reform law), a Summary of Benefits and Coverage ("SBC") is now available on *mConnect* and on the MPS Website, mpsmke.com, click Careers > Benefits Summary.

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

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

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

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

Question: How can I access the SBC and the Glossary on the MPS website?
Answer: You do not need a password to access the website to obtain the SBC that pertains to the MPS health plan you are enrolled in. Active employees may go to *mConnect* and retirees may go to the MPS Website, mpsmke.com, click Careers > Benefits Summary. If you want more detailed information about your benefits, please contact UnitedHealthcare at 1-877-440-5982 for medical and pharmacy benefits. We thank you for your continued cooperation.

Women's Health & Cancer Rights Acts of 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and
- Physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

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

ADDITIONAL NOTICES

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

In accordance with the requirements of the Affordable Care Act ("ACA") also known as the health care reform law, all employees (applicable COBRA or non-Medicare retirees as well) who were full-time or were covered under an MPS non-Medicare plan for one or more months of the 2023 calendar year will receive a form 1095-C. This form is used to report your offer of health coverage and enrollment in health coverage from Milwaukee Public Schools and will also be filed and furnished to the IRS. If applicable, you can expect to receive this 1095-C by March 2, 2024 or the next business day if March 2 falls on a weekend or holiday. The 1095-C will report to you (the employee, applicable COBRA participant, or non-Medicare retiree) and your covered dependents that you were offered minimum essential coverage under a MPS plan, if eligible. When filing your tax return, you will use this form to report your insurance coverage during the year to comply with the Affordable Care Act. See example of Form 1095-C.

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

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

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

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

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

John Doe
1234 Main Street
Milwaukee, WI 53208

INFORMATION ONLY

APPLICABLE LARGE EMPLOYER'S identification number (EIN): 39-6003457

EMPLOYEE'S social security number (SSN): XXX-XX-1234

Part II Employee Offer of Coverage

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

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

Department of the Treasury -- IRS

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

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

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

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

Claims Denials and Appeal

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

How to Appeal a Denied Claim

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

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

You may draft your written communication including the information listed above or you may use a Member Service Request Form located on the UHC member website. Log-in under your user name and password, click on the Claims & Accounts > click on *What can we help you do?* > select Submit a Medical Appeal from the drop-down list > then go to the bottom of the page and select Member Service Request Form. You or your authorized representative may send this written request for an appeal to: UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

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

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

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

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

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

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

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

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

Dependent Status Change Required Notices

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

If you divorce:

- Your ex-spouse and your step-child(ren) from that marriage are no longer eligible to be covered as dependents under MPS health and dental plans
- **You must remove ineligible dependents** from your MPS health and dental plan by contacting MPS and completing an MPS Benefits Termination Form

- If your ineligible dependents are kept on MPS health/dental plans, you can face penalties up to and including discipline, termination of employment and repayment to MPS for claims/premiums paid for ineligible dependents
- Failure to notify MPS within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) may also result in the loss of rights to self-pay for COBRA continuation coverage

If your spouse or other covered dependent dies:

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

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

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

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

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

If you are eligible for Medicare and did not enroll:

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

REMEMBER…….

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

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

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

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

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

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

How your benefits are impacted if you suffer a sickness or injury caused by a third party?

The Plan has a right to subrogation and reimbursement.

Right of Recovery

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

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will require that the overpayment be returned when requested, or reduce a future benefit payment for you or your dependent by the amount of the overpayment.

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

Right to Subrogation

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

Right to Reimbursement

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

Third Parties

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

Subrogation and Reimbursement Provisions

As a covered person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party;
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right;

- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT NOTICE/DISCLAIMER

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

Non-Discrimination Notices

Nondiscrimination Notice

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

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

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

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

Employment Nondiscrimination

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

James Gorton (414) 475-8161; gortonjr@milwaukee.k12.wi.us, Manager, Employee Rights Administrative Department (ERAD), has been designated to respond to requests for disability-related job accommodations. Yashica Spears, (414) 475-8427; spearsyq@milwaukee.k12.wi.us, EEO Compliance Specialist, ERDA, has been designated to respond to internal complaints regarding employment discrimination. ERAD can be contacted in the Office of Human Resources at Milwaukee Public Schools, 5225 W. Vliet Street, Room 128, P.O. Box 2181, Milwaukee, WI 53201-2181.

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

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

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

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

APPENDIX A: HEALTH BENEFITS SUMMARY - Effective January 1, 2024

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

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

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

BENEFITS / SERVICES Subject to Medical Necessity	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
AMBULANCE	80% after deductible	80% after deductible**	80% after deductible	80% after deductible	80% after deductible**
HOSPITAL SERVICES Inpatient Outpatient (includes outpatient therapeutic treatments) Surgery Physician In-Hospital Services	80% after deductible	50% after deductible**	80% after deductible	80% after deductible	50% after deductible**
PHYSICIAN SERVICES Office Visits – Primary Care Physician (Non-Surgical)	100% after $20 co-pay per visit	50% after deductible	100% after $20 co-pay per visit.	80% after deductible	50% after deductible**
ROUTINE PHYSICALS	100% after $20 co-pay per visit SEE PREVENTIVE CARE	50% after deductible	100% after $20 co-pay per visit. SEE PREVENTIVE CARE	100% For Preventive Care; 80% after deductible if not covered under Preventive	50% after deductible
IMMUNIZATIONS	100% after $20 co-pay; $35 co-pay if Specialist SEE PREVENTIVE CARE	50% after deductible	100% after $20 co-pay; $35 co-pay if Specialist SEE PREVENTIVE CARE	100% for Preventive Care	50% after deductible
PREVENTIVE CARE	100% of eligible expenses	50% after deductible	100% of eligible expenses	100% of eligible expenses	50% after deductible
SPECIALISTS (Office Visits) Other Physician Services	$35 co-pay per office visit.	50% after deductible	$35 co-pay per office visit.	80% after deductible	50% after deductible**
CONTRACEPTIVES	100% no deductible as specified under Health Care reform.	50% after deductible	100% no deductible as specified under Health Care Reform.	100% no deductible as specified under Health Care Reform	50% after deductible

BENEFITS / SERVICES Subject to Medical Necessity	**MPS PPO UHC –Choice Plus IN-NETWORK**	**MPS PPO UHC Choice Plus OUT-OF-NETWORK**	**MPS EPO UHC– Choice IN-NETWORK ONLY**	**MPS HDHP UHC – Choice Plus IN-NETWORK**	**MPS HDHP UHC– Choice Plus OUT-OF-NETWORK**
DENTAL SERVICES **Oral Surgery** **Accident Only**	80% after deductible-specific list of oral procedures covered. Dental implants excluded. 80% after deductible and within 72 hrs of accident	50% after deductible-specific list of oral procedures covered.** Dental implants excluded. 80% after deductible and within 72 hrs of accident	80% after deductible-oral surgery limited to surgical removal of impacted wisdom teeth only. Dental implants excluded. 80% after deductible and within 72 hrs of accident	80% after deductible Oral surgery limited to surgical removal of impacted wisdom teeth only. Dental implants excluded.	50% after deductible** Oral surgery limited to surgical removal of impacted wisdom teeth only. Dental implants excluded.
DURABLE MEDICAL EQUIPMENT (Including cochlear implants)	80% after deductible	50% after deductible**	80% after deductible; Single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.	80% after deductible; Single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.	50% after deductible** Single purchase (including repair/ replacement) of a type of DME once every 3 calendar years as specific and approved through UHC care coordination.
EMERGENCY HEALTH SERVICES	100% after $150 co-payment per visit	100% after $150 co-payment per visit**	100% after $125 co-payment per visit	80% after deductible	80% after deductible**
FERTILITY SOLUTIONS (including artificial insemination, assisted reproductive technologies, and in vitro fertilization) For more information, call 1-866-774-4626 or visit: myuhc.phs.com/fertility	$35 co-payment per office visit, 80% after deductible Lifetime maximum of $30,000; combined in and out-of-network	50% after deductible** Lifetime maximum of $30,000; combined in and out-of-network	$35 co-pay per office visit. 80% after deductible Lifetime maximum of $2,000	Exclusion: Health services and associated expenses for infertility treatments including assisted reproductive technology regardless of reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.	Exclusion: Health services and associated expenses for infertility treatments including assisted reproductive technology regardless of reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

BENEFITS / SERVICES *Subject to Medical Necessity*	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC– Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC– Choice Plus OUT-OF-NETWORK
HEARING AIDS **For dependent children under 18 years of age. Limit of one hearing aid per ear every three years.**	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible
HOME HEALTH CARE	80% after deductible Up to 120 visits per calendar year, combined in and out-of-network.	50% after deductible** Up to 120 visits per calendar year, combined in and out-of-network.	80% after deductible, up to maximum of 60 visits when approved in advance by UHC Care Coordination.	80% after deductible, up to maximum of 60 visits when approved in advance by UHC Care Coordination.	50% after deductible** Up to maximum of 60 visits when approved in advance by UHC Care Coordination.
HOSPICE CARE	80% after deductible Lifetime maximum up to 45 days for inpatient care, combined & out-of-network	50% after deductible** Lifetime maximum up to 45 days for inpatient care, combined & out-of-network	80% after deductible Lifetime maximum up to 360 days.	80% after deductible	50% after deductible**
LAB, X-RAY, DIAGNOSTICS and THERAPEUTIC TREATMENTS - OUTPATIENT (including allergy testing, chemotherapy, MRI, CT, etc.) **For preventive lab/x-ray procedures, refer to Preventive Care services category.**	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible**

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

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

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

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

APPENDIX B: DENTAL

DELTA DENTAL

MPS MILWAUKEE PUBLIC SCHOOLS

YOUR DENTAL BENEFITS

Prepared for the employees of Milwaukee Public Schools

The summary below does not cover all plan details. Further information can be found in the Summary Plan Description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

	EPO Plan (00420) MUST See a PPO Provider			PPO Plan (90114) Free to See Any Provider*		
***Deductible applies* *^ Age limitations may apply*	**Delta Dental PPO™ Network**	**Delta Dental Premier® Network**	**Out-of-Network**	**Delta Dental PPO™ Network**	**Delta Dental Premier® Network**	**Out-of-Network***
Individual Annual Maximum	$3,000	$0	$0	$1,500	$1,500	$1,500
Deductible – Ind./Family	$25	n/a	n/a	$25 / $75	$25 / $75	$25 / $75
Diagnostic & Preventive Exams, cleanings, fluoride treatments^, X-rays, space maintainers^, sealants^, emergency treatment to relieve pain	100%	0%	0%	100%	100%	100%
Basic & Major Services Fillings, root canals, gum disease treatment, simple extractions, and other oral surgery	100%**	0%	0%	80%**	80%**	80%**
Crowns, repairs & adjustments to bridges and dentures Bridges, dentures, and implants	80%**	0%	0%	80%** 50%**	80%** 50%**	80%** 50%**
Child-Only Orthodontic Coverage copayment Individual lifetime maximum Dependents eligible to Deductible	100% Unlimited Age 19 $750	No Coverage	No Coverage	50% $1,500 Age 19 None	50% $1,500 Age 19 None	50% $1,500 Age 19 None
CheckUp™ Plus	Yes	No	No	No	No	No
EBICP	Yes	No	No	Yes	Yes	Yes
Dependent Eligibility	Dependents are covered to the end of the month (EOM) they turn 26		n/a	Dependents are covered to the EOM they turn 26		

***If you visit an out-of-network provider, you will be responsible for the difference between the provider's charges and the amount your Delta Dental plan pays.**

CheckUp™ Plus allows enrollees to get diagnostic and preventive dental services without those costs getting applied to the individual annual maximum – leaving more flexibility for restorative care that might be needed later.

Evidence-Based Integrated Care Plan (EBICP) provides additional cleaning(s) and/or fluoride treatments to individuals with specific medical conditions that have oral implications.

Need assistance? Contact Customer Service at 800-236-3712 or claims@deltadentalwi.com. Learn more at www.deltadentalwi.com.

DELTA DENTAL

Choosing a Network Dentist

Discover the advantages of going to a dentist who belongs to a Delta Dental network.

With two dentist networks available, which one is right for you? The Delta Dental PPO℠ network delivers the **greatest savings**, but fewer dentists belong. The Delta Dental Premier® network is the **largest dentist network**, but the savings aren't as significant as with a Delta Dental PPO provider. This illustration shows how **both networks save you money**. Seeing either a Delta Dental PPO dentist or Delta Dental Premier dentist will ensure that **treatments are guaranteed, claims are directly paid, and no balance-billing can occur.**

Example Savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
PPO Network	$1,200	$825	80%	$660	$0	$165	$375
Premier Network	$1,200	$985	80%	$788	$0	$197	$215
Out-of-Network	$1,200	$925	80%	$740	$275	$460	$0

Delta Dental PPO network

Delta Dental PPO network **dentists have agreed to charge $825 for the $1,200 service, a savings of $375.** Your **Delta Dental plan covers 80 percent** of the cost. Assuming you've already met your deductible for the year, **Delta Dental will pay $660** and you'll **pay $165.**

Delta Dental Premier network

Delta Dental Premier network dentists have **agreed to charge $985 – a savings of $215** compared to the fee the dentist charges non-network patients. Assuming you've met your deductible, **Delta Dental will cover 80 percent** of that $985, **paying $788. You'll pay $197.** That's an extra **$32 tacked on to your share of the bill** when compared to what you would have paid with a Delta Dental PPO dentist.

Out-of-network

Out-of-network dentists **have not agreed to charge a lower fee and can bill the full $1,200.** Delta Dental has set a limit on the accepted amount at $925, which means **Delta Dental's share of the tab is $740.** The dentist can bill you the difference between the maximum allowed fee and what they charge. This leaves **you with a bill of $460, which includes the $275 the out-of-network dentist can "balance bill."**

www.deltadentalwi.com

SS319-1810

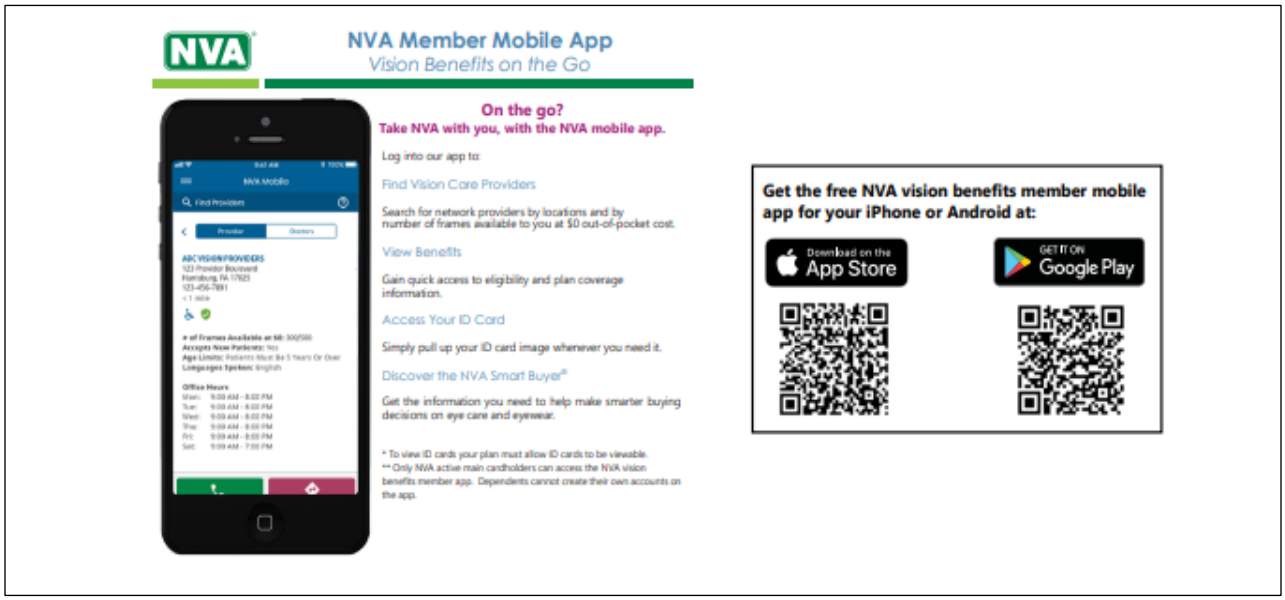
APPENDIX C: VISION

ROUTINE VISION COVERAGE

BENEFITS FOR ACTIVE EMPLOYEES ONLY

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

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



APPENDIX D: MONTHLY PREMIUM COSTS (ALL PLANS)

2024 Active Employee Premium Rate Information

Total Monthly Premium (Health and Vision):

All rates effective January 1, 2024-December 31, 2024

HEALTH PLAN	PPO/Choice Plus	EPO Plan	HDHP
Single	$1,064.77	$1,101.88	$1,011.42
Family	$2,502.53	$2,589.75	$2,353.67

Employee insurance premium share is deducted from twenty (20) paychecks, for all employees, typically starting with the first paycheck in January 2024 through the first paycheck in June 2024. Deductions will resume with the first paycheck of September 2024 through the last paycheck in December 2024. There are no "make-up" contributions for 10-month employees, and 12-month employees do not pay any premium share in July and August.

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

The charts below list the per-paycheck deduction and the annual percentage of premium contribution for each plan and salary band. NOTE: If your salary changes throughout the year, you may move into a higher salary band and your contribution would increase as of the effective date of the salary change. For hourly employees, your previous calendar year's earnings are used to set your salary band contribution every March 1st. As always, employee premium contributions are taken on a pre-tax basis.

Active Employee Per Paycheck Health and Vision Contribution:

Annual Base Salary		PPO %	PPO Employee Deduction	EPO%	EPO Employee Deduction	HDHP%	HDHP Employee Deduction
$25,000 or under	Single	11%	$70.27	5%	$33.06	2%	$12.14
	Family	11%	$165.17	5%	$77.69	2%	$28.24
$25,001 to $50,000	Single	12%	$76.66	8%	$52.89	5%	$30.34
	Family	12%	$180.18	8%	$124.31	5%	$70.61
$50,001 to $75,000	Single	13%	$83.05	10%	$66.11	7%	$42.48
	Family	13%	$195.20	10%	$155.39	7%	$98.85
$75,001 and above	Single	14%	$89.44	12%	$79.34	9%	$54.62
	Family	14%	$210.21	12%	$186.46	9%	$127.10

Dental Premiums for Active Employees

Dental Plan	Delta Dental PPO		Delta Dental EPO	
	Total Premium	Employee Per Paycheck Deduction	Total Premium	Employee Per Paycheck Deduction
Single	$27.00	$0.81	$34.52	$1.04
Family	$94.01	$2.82	$114.09	$3.42

Employee Premium Contributions – Additional Information

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

Get to know your care options and costs

How much you pay for care can depend on where you get it. For serious or life-threatening conditions, call 911 or go to an emergency room. For everything else, it may be best to contact your PCP first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the emergency room.

Care options to consider and approximate costs	START HERE PCP Care from the doctor who may know you best	24/7 Virtual Visits See a doctor whenever, wherever	Convenience care Basic conditions that aren't generally life-threatening	Urgent care Serious conditions that aren't generally life-threatening	Emergency room Life- and limb-threatening emergencies
Average cost*	**$165**	**Less than $49****	**$100**	**$185**	**$2,500**
Hours	**Varies by location**	**24/7**	**Varies by location**	**Varies by location—may be open nights/weekends**	**24/7**
How to connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com**	**myuhc.com**	**myuhc.com**
✔ **indicates the recommended place for care for the following common conditions:**					
Broken bone				✔	✔
Chest pain					✔
Cough	✔	✔	✔		
Fever	✔	✔	✔		
Muscle strain	✔		✔		
Pinkeye	✔	✔	✔		
Shortness of breath					✔
Sinus problems	✔	✔	✔		
Sore throat	✔	✔	✔		
Sprain	✔		✔	✔	
Urinary tract infection	✔	✔	✔		

Need to find a network provider or PCP?

Visiting an out-of-network provider could end up costing you more for care. To find a PCP, urgent care centers and emergency rooms in your network, go to **myuhc.com**.

Not sure where to go for care? Call the number on your health plan ID card.

*Source 2020. Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,315 difference between the average emergency room visit, $2,500 and the average urgent care visit $185.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

Check your official health plan documents to see what services and providers are covered by your plan.

BENEFIT PROVIDERS CONTACT INFORMATION			
HEALTH			
EPO UnitedHealthcare (Choice)	1-877-440-5982	Group No.: 703772	www.myuhc.com (select "Choice")
PPO UnitedHealthcare (Choice Plus)	1-877-440-5982	Group No.: 703772	www.myuhc.com (select"Choice Plus")
HDHP UnitedHealthcare (Choice Plus)	1-877-440-5982	Group No.: 703772	www.myuhc.com (select "Choice Plus")
MPS Group Medicare Advantage Plan	1-866-487-9303		www.UHCRetiree.com
PRESCRIPTION DRUG			
OptumRx	1-877-440-5982	Group: UHEALTH	www.optumrx.com
VISION			
National Vision Administrators (NVA)	1-800-672-7723	Group No. 00148	www.e-nva.com
DENTAL			
Delta Dental	1-800-236-3712	PPO Group No.90114 EPO Group No.00420	www.deltadentalwi.com
FLEXIBLE SPENDING ACCOUNTS			
P&A Group	1-800-688-2611		www.padmin.com
HEALTH SAVINGS ACCOUNT			
Optum Bank (HSA)	1-844-326-7967		https://www.optumbank.com/
LIFE INSURANCE, SHORT TERM DISABILITY, & LONG TERM DISABILITY			
The Standard On-site Acct Specialist	414-475-8699	Group No.: 753788	mpsbenefits@standard.com
Standard Insurance Company	1-800-628-8600	Group No.: 753788	standard.benselect.com
PENSION			
City Pension Office (ERS)	414-286-3557		www.cmers.com
State Pension Office (WRS)	1-877-533-5020		www.etf.wi.gov
TAX DEFERRED ANNUITIES – 403(b)			
Voya Financial Services	Local Representative Team: 414-256-2187 Customer Service: 800-684-5001		
MetLife	414-615-4926		
TIAA	National Contact Center: 1-888-842-7782 Enrollment Hotline: 1-800-842-2005, ext.255611		
WEA TSA Trust	1-800-279-4030, ext. 8577; Local Contact: 414-259-1990		
Plan With Ease	1-855-464-6928		www.planwithease.com
DEFERRED COMPENSATION PROGRAM – 457			
Wisconsin Deferred Compensation	1-877-457-9327 - Option 2		www.wdc457.org
EMPLOYEE ASSISTANCE PROGRAM (EAP) – FEI			
Employee Assistance Program (EAP)	1-800-638-3327 Code: MPSEAP		http://myassistanceprogram.com/fei/ Code: MPSEAP
FAMILY MEDICAL LEAVE			
Sedgwick	1-844-263-3120		timeoff.sedgwick.com
MPS CONTACTS			
Flexible Spending Accounts		414-475-8178	alvarer@milwaukee.k12.wi.us
Health/Vision, Dental (last names A – F)		414-475-8158	benefits@milwaukee.k12.wi.us
Health/Vision, Dental (last names G – L)		414-475-8233	benefits@milwaukee.k12.wi.us
Health/Vision, Dental (last names M – R)		414-475-8215	benefits@milwaukee.k12.wi.us
Health/Vision, Dental (last names S – Z)		414-475-8559	benefits@milwaukee.k12.wi.us
Leave of Absence		414-475-8161	mezamn@milwaukee.k12.wi.us
Payroll		414-475-8300	payroll@milwaukee.k12.wi.us
Pension/Tax Deferred Annuities Including: Deductions/Loans/Hardship Withdrawals		414-475-8730	MPSPension@milwaukee.k12.wi.us