CITY OF DE PERE

2025 EMPLOYEE BENEFITS GUIDE

Updated: 02/2025

M3 INSURANCE

REFERENCE GUIDE

TOPIC	VENDOR	CONTACT INFORMATION
Medical	UMR	Medical: 1.800.826.9781 www.umr.com
Pharmacy	National Coop. / CVS Caremark	1.866.818.6911 www.caremark.com
Dental	Delta Dental	1.800.236.3712 www.deltadentalwi.com
	Dental Associates / Care Plus	1.800.318.7007 www.careplusdentalplans.com
Vision	United Healthcare (UHC)	1.800.638.3120 www.myuhcvision.com
Flexible Spending Account (FSA) Health Reimbursement Account (HRA)	Employee Benefits Corporation (EBC)	1 800.346.2126 www.ebcflex.com
Short Term Disability (Income Continuation Insurance)	State of Wisconsin Department of Employee Trust Funds (Administered by The Hartford)	1.800.960.0052 ICIQuestions@thehartford.com
Long Term Disability (LTD)	The Standard	1.800.368.1135 www.standard.com
Life Insurance	State of Wisconsin Department of Employee Trust Funds (Securian Financial Group)	1.866.295.8690 www.securian.com
Deferred Compensation Plans	Wisconsin Deferred Compensation (WDC) Plan #98971-01	www.wdc457.org WDC Customer Care Center: (877) 457-9327
	Nationwide Retirement Solutions Policy #4910	www.nrsforu.com Customer Service Rep: Kerryl V. Johnson (608) 825-2516 Johnk46@nationwide.com
Pension Plan	Wisconsin Retirement System (WRS) City ID #69-036-0974	1.877.533.5020 608.266.3285 (Madison) www.etf.wi.gov
Employee Assistance Program (EAP)	Advocate Aurora Health (AAH)	1.800.236.3231 www.aah.org/eap
Identity Fraud Expense Reimbursement	Travelers Insurance	1.800.842.8496 bfpclaims@travelers.com

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request. The intent of this document is to provide you with general information regarding the status of and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issue. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice

BENEFITS AT A GLANCE

Health and Dental Insurance *(pgs.7-8, 22-40):* The City maintains a self-insured health insurance plan administered by a third-party provider. The City offers two plan options for dental insurance, a self-insured option and a fully insured option. Full-time non-represented employees pay 10% and represented employees pay 15% of the premium for both medical and dental plans, part-time employees pay a pro-rated amount. Premiums are taken pre-tax. Regular full-time and regular part-time employees are eligible for health and dental insurance coverage for themselves and their families.

> **Teladoc (Telemedicine Platform)**: Teledoc is an add-on service integrated with UMR, the City's third party administrator. This benefit provides anytime access to on-call doctors for *some Medical and Behavioral Health concerns.* It connects members to a network of physicians who can diagnose, treat and prescribe medications when needed. It offers one on one consultation where patients have the option to communicate via phone, online video or mobile app. The cost for a visit through Teledoc will be **$0 for any member of the City's health insurance plan**. This benefit provides a low cost alternative to in-person doctor's visits.
>
> **Real Appeal Wellness Program***:* This is an online weight loss program available to you and eligible family members at no additional cost through your health benefits plan.

Vision Insurance *(pgs.9, 50-52):* This is a fully insured plan and the entire cost of the monthly premium is paid by the employee through payroll deduction. Premiums are taken pre-tax.

Life Insurance *(pg. 10):* The State's Department of Employee Trust Funds (ETF) administers the Life Insurance Program. Premium rates are based on age, earnings, and number of units purchased. Coverage options: Basic, Additional, Spouse & Dependent; purchasing Basic is a prerequisite for purchasing additional units. Employees are responsible for updating beneficiaries with ETF as necessary when status changes occur (birth, death, divorce, etc.). Enrollment in WRS is required to be eligible for the Voluntary Life Insurance.

Short Term Disability (Income Continuation Insurance) *(pg. 11):* This program provides short term income replacement on a monthly basis if you are unable to work because of sickness or injury. The benefit is voluntary for all employees who participate in the Wisconsin Retirement System and currently is available at no cost (as a result of a premium holiday).

Long Term Disability *(pg. 12):* This program provides monthly benefits for the partial replacement of income while an employee is disabled (disabled is defined as more than three months), unable to work and under the care of a doctor. Employees working at least 20 hours per week are automatically enrolled. The LTD benefit is a City sponsored benefit and is no cost to the employee.

Health Reimbursement Account (HRA) *(pgs. 13, 41-49):* An HRA is an IRS approved tax-free benefit that reimburses plan members for out-of-pocket expenses not paid by the health or dental insurance plan. The amount is based on the type of medical coverage selected and prorated based on the medical coverage effective date. Active medical plan members are automatically enrolled in the HRA.

Employees enrolled in the health plan receive dollars in their Health Reimbursement Account (HRA) every January. Preventative exams are not required for members to be eligible for the health plan, but are encouraged as the funding of the health reimbursement account (HRA) will be affected by participation

Section 125 (Flexible Spending Account) *(pgs. 14, 41-49):* Flexible spending is an easy way for employees to set aside a portion of their earnings, and use it to pay for health care and daycare expenses. The money set aside in the flexible spending plan is free from payroll taxes, so employees see tax savings for each dollar they contribute. Enrollment eligibility and changes to the flexible spending account during the calendar year are subject to qualifying events.

Wisconsin Retirement System (WRS) *(pg. 15):* The Wisconsin Retirement Program is a pension plan which helps provide for financial security during retirement. Monthly annuity payments at retirement are calculated using years of creditable services, average earnings (based on three highest years of earnings), formula factors, age at retirement and selected annuity option or a money purchase option. Regular employees working at least 1200 hours a year (600 hours for employees covered prior to 7-11-11) are automatically enrolled.

BENEFITS AT A GLANCE (continued)

Employee Assistance Program (EAP) *(pg. 16):* The City of De Pere has an Employee Assistance Program (EAP). The services offered are a benefit provided by the City of De Pere at no cost to its employees and their immediate family members to help deal with life's stresses. EAP consists of caring individuals who are certified counselors. They offer professional support and direction towards resolving problems or concerns. They can also help by referring the employee to another resource if assistance is needed beyond the EAP.

Wellness *(pgs. 17-21):* Permanent full-time and part-time employees and their spouses can participate in the City's Wellness Incentive Program. Participants in the Wellness Incentive Program receive points for things such as participating in a run/walk, getting an annual physical each year, exercising, and completing preventative screenings. Participants can pick and choose what activities they would like to participate in and submit points to earn gift cards. Participation is completely voluntary but will benefit participant's lifestyle and may help save money on health care costs in the future. Employees and their immediate family members are also offered a 25% discount on all City of De Pere Park and Recreation exercise and movement- based programs. We can all take steps, even small ones, to improve our overall well-being.

Section 457 Deferred Compensation Program/Roth IRA: The Deferred Compensation program allows employees to defer a portion of their salary for future supplemental retirement income at their expense through payroll deduction. The amount deferred reduces state/federal income taxes and earnings as these deferrals accumulate tax-free until withdrawn. There are two plans to choose from, one through Nationwide Retirement Solutions and the other through the Wisconsin Deferred Compensation Plan (WDC). Each plan has its own enrollment requirements and mutual funds to choose from.

Employees can elect to have earnings deducted from their pay and put into a Roth IRA account through the Wisconsin Deferred Compensation Plan or Nationwide Retirement Solutions. A Roth IRA account provides an opportunity to build retirement assets by making post tax contributions.

Enrollment is voluntary and employees can participate in one or all of the plans. Changes to contribution amounts or investment options can be made at any time by completing the provider's forms. Forms and additional information is available by contacting the plan provider (contact information is provided on page 2).

Identity Fraud Expense Reimbursement *(pgs.53-54):* This benefit provides all eligible employees with 100% employer-paid fraud expense reimbursement coverage up to $25,000. This benefit is provided to employees free of charge.

Public Service Loan Forgiveness (PSLF) *(pg. 55)*: The PSLF Program is a program offered by the US Department of Education. The program forgives the remaining balance on your Direct Loans after you have made 120- qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer.

Required Federal Notices *(pg. 56-70)*

ENROLLMENT PROCEDURES

In compliance with the Affordable Care Act (ACA) the City will hold an open enrollment each fall at which time employees will be able to make changes to, or apply for, benefit coverage for the next calendar year. Enrollment for employee benefit insurance coverage is subject to the requirements of the specific summary plan document, agreements between the vendor and the City or vendor requirements. To accommodate these requirements, the following procedures will be followed regarding new employee and current employee enrollment.

New Employees*:* New employees in a position eligible for benefits may enroll within 31-calendar days of the hire date for health, dental and/or vision insurance, 30-calendar days for life insurance and Section 125 flexible spending account. The effective date of coverage for health, dental, vision, long-term disability, and flexible spending is the first day of the month following the date of hire. Life Insurance coverage is effective the first day of the month following 30 days from the date of hire. Identity Fraud Expense Reimbursement is effective on the date of hire. Eligibility for benefits will be in accordance with the definition under each summary plan document. If the new employee declines coverage for self, spouse and/or eligible dependents, the employee may apply for coverage for self, spouse and/or eligible dependents at the next open enrollment period, if applicable, except in the case of a qualifying event that permits earlier enrollment. To complete enrollment, Human Resources will need to see the birth certificates of your dependents, and marriage certificate, if applicable.

Current Employees*:* Following initial employment, current employees may change or apply for medical coverage, dental, vision and flexible spending annually during the open enrollment period for the next calendar year, except in the case of an event that permits changes during the calendar year in accordance with the specific summary plan document. If a current employee declines coverage for self, spouse and/or eligible dependents, the employee may apply for coverage for self, spouse and/or eligible dependents at the next open enrollment period except in the case of a qualifying event that permits earlier enrollment.

Special Enrollment for Life Insurance: Employees may enroll for one level of employee coverage or increase their employee coverage by one level if they have a qualifying family status change event. If the employee does not enroll for coverage within 30 days of a family status change event or when first hired, the employee may obtain coverage by providing the insurer, Securian Financial Group, with satisfactory evidence of insurability at their own expense.

Qualifying Events: Qualifying events under HIPAA Special Enrollment and Section 125 (Flexible Spending Accounts):

- Marital status change: marriage, death of spouse, divorce, annulment or legal separation.
- Number of dependents change: birth, adoption or placement for adoption, death of dependent child, newly eligible dependents due to plan design change.
  - HIPAA allows the employee who may have elected employee only coverage initially to not only add a new dependent, but also allows the employee to add the spouse at the time the new dependent is added.
  - HIPAA does not require all eligible dependents (i.e., other dependent children) be added.
  - Loss of coverage: if the employee loses other coverage (e.g. Spouse's health plan coverage terminates, or Medicare or Medicaid eligibility ends).

Changes to plan elections may be made under section 125 (flexible spending account) rules under the following circumstances (in addition to the HIPAA special enrollment events):

- Dependent status change: dependent no longer satisfies rule for eligibility as a dependent due to attainment of age, marriage of dependent child
- Employment status: commencement or termination of employment, commencement of or return from leave of absence, change from part-time to full-time status or vice versa, strike or lockout.
- Judgment decree or order requiring coverage: QMSCO.
- Change in residence: may qualify if there is a loss of eligibility for a region-specific plan, such as an HMO.
- Change in cost of dependent care expenses (for dependent care flexible spending only)
- Other additional circumstances as allowed under section 125.

ENROLLMENT CHANGES

If an employee has enrollment changes for health, dental or vision insurance, please contact the Human Resources Department at 920-339-4045. A new enrollment form must be completed reflecting the changes to be made to the insurance coverage.

Some examples include: (not an all-inclusive list)

- Adding a newborn baby or adopted child
- Adding a spouse due to marriage
- Removing a spouse and/or children due to divorce
- Removing a child who reaches age 26
- Removing a spouse who reaches age 65
- Loss of coverage

Plan Administrators cannot authorize any changes to health, dental and/or vision insurance coverage. All insurance changes must be made by the Human Resources Department.

Please note the following time limits:

- For a **child** to be enrolled as of the date of birth or adoption date, an enrollment form must be submitted to Human Resources within **60 days** of the birth or adoption date along with a copy of the birth certificate. *(The Social Security Number takes about 6 weeks to receive so send in the enrollment form within the 60 days and then call with the number when it is received.)*

- For a **spouse** to be enrolled as of the date of marriage, an enrollment form must be submitted to Human Resources within 31 days of the date of marriage along with a copy of the marriage certificate.

MEDICAL

UMR	CHOICE PLUS NETWORK	
	In-Network	**Out-of-Network**
Embedded Deductible		
Single	$2,000	$2,250
Employee + One	$2,000 per person	$2,250 per person
Family	$4,000 (or $2,000 per person)	4,500 (or $2,250 per person)
Out-of-Pocket Maximum		
Single	$4,000	$5,000
Employee + One	$7,000	$8,000
Family	$8,000	$9,000
Coinsurance	80%	60%
Lifetime Maximum	Unlimited	
Routine / Preventive Care	100% Covered *(includes Vision and Hearing Screenings)*	Deductible & Coinsurance Apply *(no benefit for out-of-network vison exams)*
Teladoc (Virtual Care)	***FREE***	N/A
Real Appeal Weight Loss Program	***FREE***	N/A
Bellin Services (Primary Care | Urgent Care | FastCare | PT)	***FREE***	N/A
Prevea Services (Primary Care | Urgent Care | PT)	***FREE***	
Office Visits		
Primary Care Physician	$20 Copay	Deductible & Coinsurance Apply
Specialist	$40 Copay	
Mental Health Services	$0 Copay	
Hospital Services	Deductible & Coinsurance Apply	Deductible & Coinsurance Apply
Urgent Care	$40 Copay	Deductible & Coinsurance Apply
Emergency Room	$200 Copay, then In-Network Deductible & Coinsurance	
Retail Prescription Coverage		
Level 1	$10	
Level 2	$20	
Level 3	$40	
Level 4	20% Copay to $350 Maximum per prescription	
Members can receive a 90 day supply of medication for the cost of 60-days at CVS/Target, Costco, or through mail order.		

Please note: Copays do not track toward the deductible however they do track to the out-of-pocket maximum.

This is a summary of benefits and features offered by the City of De Pere and UMR.
All benefits are subject to the limitations, and exclusions set forth in the Summary Plan Description.

Additional HRA dollars can be earned by simply completing the **preventative exams:**

Health Reimbursement Account	City Contribution	Preventative Exams Completion Credit (Employee)*	Preventative Exams Completion Credit (Spouse)	Total Credit
Single	$500	$500	-	$1,000
Employee + One	$1,000	$500	$500	$2,000
Family	$1,000	$500	$500	$2,000

**If an employee is on an employee +1 or family plan but does not have a spouse, the employee will receive full credit ($1,000).*

Rates *(based on full-time employment)*	Employee Premium Per Payroll (Non-Represented)	Employee Premium Per Payroll (Represented)
Employee	$33.67	$50.51
Employee + One	$62.68	$94.02
Family	$102.80	$154.20

DENTAL

	DELTA DENTAL **PPO Plus Premier**	CAREPLUS **Dental Associates & Midwest Dental**
Deductible		
Single	$25	$0
Family	$75	$0
Annual Maximum	$1,250	$2,000
Preventive Services *do not track toward annual maximum*		
Oral Exams *(2) per year*	100%	100%
Bitewing X-Rays *(1) per year Delta Dental; (2) per year Dental Associates*	100%	100%
Full Mouth or Panoramic X-Rays *(1) per (5) years Delta Dental; (1) per (3) years Dental Associates*	100%	100%
Cleanings *(2) per year*	100%	100%
Topical Fluoride *to age 19 (2) per year Delta Dental; to age 15 (2) per year Dental Associates*	100%	100%
Sealants *on molars to age: 19 Delta Dental; 15 Dental Associates*	100%	100%
Space Maintainers	100%	100%
Pre-diagnostic testing *age 40 and older Delta Dental; (1) per year Dental Associates*	100%	100%
Basic Services		
Problem- focused evaluation (emergency)	80%	100%
Palliative (emergency) treatment for pain relief	80%	100%
Fillings	80%	100%
Extractions	80%	100%
Oral Surgery & Drug injections	80%	100%
Periodontal evaluations, maintenance, & Surgery	80%	100%
Pulp Tests & Pulpotomies on primary teeth	80%	100%
Recementation of crowns, bridges, inlays, onlays & veneers	50%	100%
Occlusal guards & adjustments	80%	100%
Stainless Steel Crowns on primary teeth	80%	100%
Major Services		
Crowns *(1) per 5 years*	50%	80%
Gold Foil Fillings	No Coverage	No Coverage
Inlays or Onlays *(1) per 5 years*	50%	No Coverage
Implants *(1) per 5 years*	50%	80%
Porcelain / Ceramic / Resin Material	50%	80%
Veneers *(anterior & bicuspid teeth) (1) per 5 years*	50%	80%
Endodontics	50%	100%
Prosthodontic Services *Installation and Maintenance/Repairs of Bridgework & Dentures*	50%	80%
Orthodontics (per course or treatment) *Orthodontic treatment in progress on your effective date will be prorated for the remainder of the treatment period. The plan does not include charges for Orthodontic services started prior to effective date of your coverage.*	50% to $1,500 Max.	50% to $2,000 Max.
Evidence-Based Integrated Care Plan (EBICP) *Provides enhanced dental benefits for people with specific existing health conditions*	Included	Included

This is a summary of benefits and features offered by the City of De Pere, Delta Dental and Dental Associates (CarePlus). All benefits are subject to the limitations, and exclusions set forth in the Summary Plan Description.

Rates Based on full-time employment	**Non-Represented**		**Represented**	
	Delta Dental Plan	**Dental Associates Plan**	**Delta Dental Plan**	**Dental Associates Plan**
Employee	$2.07	$1.73	$3.11	$2.59
Family	$6.30	$4.93	$9.45	$7.39

VISION

UNITEDHEALTHCARE	In-Network	Out-of-Network
Comprehensive Vision Exam	$10 Copay	Up To $40
Materials Eyeglass Lenses Eyeglass Frames Contact Lenses	 $25 Copay $25 Copay $25 Copay	See Below
Pair of Lenses Single Vision Bifocal Trifocal Lenticular	Covered In Full After Applicable Copay *Includes standard scratch-resistant coating*	 Up To $40 Up To $60 Up To $80 Up To $80
Frames	$130 Retail Frame Allowance *(after applicable copay)*	Up To $45
Covered Contact Lenses*	Up To 4 Boxes *Plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay)*	Up To $125
Non-Selection Contacts*^	Up To $125 *(material copay is waived)*	Up To $125
Necessary Contact Lenses	Covered In Full *(after applicable copay)*	Up To $210
Frequency Exam Lenses Frames	 Once every 12 months Once every 12 months Once every 24 months	

* *Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.*

^ *It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today. A complete list can be found by visiting our website www.myuhcvision.com.*

This is a summary of benefits and features offered by the City of De Pere and United Healthcare.
All Benefits are subject to the limitations, and exclusions set forth in the Summary Plan Description.

Rates	Employee Per Payroll
Employee	$3.06
Employee/Spouse	$5.80
Employee/Child(ren)	$6.80
Family	$9.57

LIFE AND AD&D

Wisconsin Public Employers Group Life Insurance Program Supplemental Life Information: Eligible employees include part-time and full-time employees who are covered under WRS. Employees may submit their application any time after their date of hire but it must be received before the deadline for applications. The deadline is within 30 days of:

- **A.** Your date of hire
- **B.** You return to employment after a leave without earnings if, during that absence, insurance coverage was discontinued
- **C.** Enrollment due to a Family Status Change Event
- **D.** Enrollment under Evidence of Insurability

BASIC & ADDITIONAL LIFE INSURANCE	AMOUNT OF LIFE INSURANCE
Employee - Basic Life Plan *(AD&D amount equals total amount of your insurance under Basic and Additional coverages)*	1x earnings, rounded to the next higher $1,000
Employee - Additional Life Plan (*must have Basic coverage to be eligible for the Additional Plan)*	Up to 3x earnings
Spouse & Child - Supplemental Life Plan *(AD&D is not included on the Spouse and/or Dependent Life Insurance plans)*	1 unit Spouse =$10,000; Dependent=$5,000 2 units Spouse =$20,000; Dependent=$10,000

Cost of Insurance

As a local government employee, your monthly premiums are determined as of July 1 of each year, based on your age on that date and your amount of insurance. The monthly rates for Basic and Additional insurance are available from your employer, ETF, or Securian Financial Group. Rates could change annually.

You can also find current premium rates (ET-2164) on ETF's Internet site at https://etf.wi.gov/

Local Government Employee

Basic and Additional
Rate per $1,000 of insurance July 1, 2023 – June 30, 2025

AGE	
Under 30	$.05
30-34	$.06
35-39	$.07
40-44	$.08
45-49	$.12
50-54	$.22
55-59	$.39
60-64	$.49
65-69*	$.57

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

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

(If late enrollee, you must apply through underwriting for any additional life insurance buy-up amount)

AD&D is not included on any of the Life Insurance plans for Spouses and/or Dependents

SHORT-TERM DISABILITY (INCOME CONTINUATION INSURANCE)

The City participates in the Local Income Continuation Insurance (ICI) benefit through ETF. ICI is a voluntary "income replacement" (similar to a short-term disability policy) benefit available to all employees who participate in the Wisconsin Retirement System (WRS). The Local ICI program is currently under a premium holiday – which means there are **no premiums (no cost) for 2025!**

Here are a few highlights:

- ICI benefits are payable if you become disabled and wish to take the benefit at the time of the disability. ICI does not provide income continuation for caretaking of a spouse or child, or bonding with a newborn child. ICI provides **up to 75% of your average monthly earnings,** up to $7,500 per month (up to $120,000 annual earnings), based on your previous calendar year earnings rounded to the next highest $1,000 and divided by 12. For newly hired employees, your estimated annual earnings are rounded to the next highest $1,000 and divided by 12.

- Before the benefit starts, you must serve your elimination period (also called a waiting period) which is 30-days unless you specifically enrolled in a longer elimination period. *You must be completely off work during this time.* Employees may use their sick leave, or other paid time off, until the waiting period is met. Sick leave, vacation, holiday, and compensatory time do not need to be exhausted before ICI benefit payments can begin.

- Benefits are paid monthly at the beginning of the month for the previous benefit month (i.e. January benefits are paid February 1).

- The Hartford is the Plan Administrator. All claims for ICI should be filed with The Hartford; claims may be filed up to 30 days before your anticipated last day worked in cases of impending childbirth or scheduled surgery.

- For childbirth, your ICI benefit for a normal, vaginal delivery will end 6 weeks after the date of delivery (8 weeks for an uncomplicated cesarean delivery). These time periods are standard durations used in the disability industry. However, if you have complications prior to or after delivery, ICI benefits may be paid longer, depending on whether the complication is considered disabling.

*Note: Because ICI is not administered by the City, medical certification received by the ICI Plan Administrator is not automatically received by the City. You must apply for and submit medical certification to the City to qualify for Family Medical Leave (FMLA). The FMLA application must be completed at least 30 days in advance of planned medical leave of more than three **calendar** days, or as soon as practical for unforeseen medical leave.*

We highly encourage you to read the Income Continuation Booklet (ET-2129) at http://etf.wi.gov, for detailed information on the plan.

Please review the Income Continuation Insurance and Leave Coordination document for information on how ICI coordinates with your leave time and other benefits. This document is available at www.deperewi.gov/benefits, then click on Short-Term Disability.

LONG TERM DISABILITY

By offering partial income replacement, Long Term Disability Insurance can help to lighten the financial load if you become unable to work due to a disability. Coverage is provided to you by the City of De Pere at no cost and no action is required on your part if you are an employee working 20 hours per week.

The Standard is the insurance carrier for your long term disability coverage.

COVERAGE BASICS	LONG TERM DISABILITY (LTD) BENEFIT SUMMARY
Effective Date of Eligibility	Coverage is effective the first of the month following date of hire, unless you are hired on the first, then it's effective on date of hire.
Scheduled Benefit Amount	60% of monthly pay subject to a maximum scheduled amount of $5,000 per month.* *Monthly pay means your basic monthly pay and is determined on the day before the period of disability starts. Bonuses, overtime, and other compensation is not considered as basic wages or salary. However, a monthly average of commissions received during the prior full calendar year will be included. If you are an hourly employee, monthly pay will be based on your hourly rate of pay.* *The City of De Pere will be covering the additional premium needed to offset taxes at time of disability payment, ensuring that employees will receive the full 60% of their earnings for any long term disability.* **The City of De Pere will purchase additional coverage for employees over the current maximum amount to ensure all employees receive a 60% benefit amount, regardless of annual salary. Public Safety employees are subject to medical underwriting (required by the company).*
Minimum Benefit	If you normally work at least 30 hours per week before your period of disability starts, the minimum monthly benefit will be $100.
Qualifying Period	3 months
Maximum Benefit Period	Benefits will not be paid beyond the maximums stated below:

AGE	MAXIMUM BENEFIT PERIOD
Before 60	The day before retirement age *
60 but before 65	The day before retirement age * or 36 months of disability ** *whichever is longer*
65 but before 68	24 months of disability **
68 but before 70	18 months of disability **
70 but before 72	15 months of disability **
72 or more	12 months of disability **

*"Retirement age" means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act.

**following the end of the qualifying period

This summary of Benefits and the Brochure and Enrollment Form explain/explains the general purpose of the insurance described, but in no way changes or affects the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply.

LTD products contain limitations and exclusions, complete coverage information can be found in your Booklet-Certificate if you become insured. Please read it carefully and keep it in a safe place with your other important papers.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Each year the City of De Pere sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period, and establish that all 213 D medical expenses are allowed for reimbursement under their plan. The account is administered by Employee Benefits Corporation (EBC). The amount is based on the type of medical coverage selected, and prorated based on your medical coverage effective date. Like Flex Spending, your HRA monies can be used to reimburse you for expenses not paid by the City's medical plan such as deductibles, copays, etc.

1. **How much will be contributed to my HRA?**

HRA	City Contribution	Preventative Exams Completion Credit (Employee)*	Preventative Exams Completion Credit (Spouse)	Total Credit
Single	$500	$500		$1,000
Employee + One	$1,000	$500	$500	$2,000
Family	$1,000	$500	$500	$2,000

**If an employee is on an employee +1 or family plan but does not have a spouse, the employee will receive full credit ($1,000).*

2. **What can I pay for with my HRA fund?**
   - Co-insurance
   - Prescription Drugs
   - Out of pocket medical expense
   - Dental/Vision expenses
   - All other 213(d) eligible medical expenses (same as for flex spending)

3. **What happens to my account when I retire or am no longer working for the City?**
   - Retirement/Disability/Layoff or Reduction in Workforce: employee gets to keep 100% contribution.
   - Voluntary Separation/Pass Away: You get to keep 100% after 10 years (10%/year vested). After 10 years, 100% of the fund stays with you. If you are employed for less than 10 years, that amount is pro-rated per year; 10% of the fund will stay in the account for each year of being on the plan (Example: 5 years = 50% of the funds). If you pass away, your HRA may continue to be used by your beneficiary for reimbursement of your medical expenses or, the medical expenses of your beneficiary, even if your beneficiary is not enrolled in the City's health insurance plan.
   - Involuntary Termination: You get to keep 50% after 10 years (5%/year vested). After 10 years of being on the HRA, 50% of the fund stays with the employee. If the employee is on the HRA for less than 10 years, the amount is pro-rated per year. 5% of the fund will stay in the account for each year of being on the plan (Example: 5 years = 25%).
   - The City pays the monthly administrative fee to have the HRA fund administered. Once you are no longer an employee, that administration fee will automatically be taken from your HRA fund at the end of the calendar year.

For additional FAQs please visit the City of De Pere's website.

SECTION 125 FLEXIBLE SPENDING ACCOUNT (FSA)

EMPLOYEE BENEFITS CORPORATION (EBC)

Flexible spending is an easy way for employees to set aside a portion of their earnings, and use it to pay for health care and daycare expenses. The money set aside in the flexible spending plan is free from payroll taxes, so employees see tax savings for each dollar they contribute.

This is an optional feature and enrollment is voluntary. During open enrollment a current employee may enroll in the flexible spending account for the next calendar year. Enrollment eligibility and changes to the flexible spending account during the calendar year are subject to qualifying events.

The maximum annual health care reimbursement amount an employee may elect for the 2025 plan year is **$3,300** and may be adjusted annually.

The City will allow the statutory maximum ($660 as of plan years beginning January 1, 2025) of unused funds remaining in your Health Flexible Spending Account (FSA) to be rolled over to the subsequent Plan Year. These rollover funds may be only used to pay or reimburse medical expenses under the Health FSA.

Dependent Care Spending Account elections cannot exceed **$5,000** per year. Dependent Care expenses are reimbursed up to the cash balance in your account. Unpaid claims are reimbursed as more money is credited to your account. The City of De Pere has a 2 ½ month grace period to incur claims for dependent care.

If you are utilizing the Employee Benefits Corporation Benefits Card, the funds will be taken from your flexible spending account first, then from your Health Reimbursement Arrangement (HRA) Account.

WRS CONTRIBUTION RATES

Wisconsin Retirement System (WRS) benefits consist of employer required and employee required contributions. Unless otherwise indicated by state regulation or union contracts, the City will pay the employer required share into the plan, and employees will be responsible for contributing the employee share. The employee contributions will be deducted pre-tax as a percentage of reported earnings each payroll period.

Employee Category	2025 Total Rate	2025 Employee Contribution	2025 Employer Contribution*
General/Teacher	13.9%	6.95%	6.95%
Elected Official/Executive/Judge	13.9%	6.95%	6.95%
Protective with Social Security	21.96%	6.95%	15.01%
Protective without Social Security	25.96%	6.95%	19.01%

- Eligibility - The Wisconsin Retirement Program is a pension plan that helps provide for financial security during retirement. Monthly annuity payments at retirement are calculated using years of creditable services, average earnings (based on three highest years of earnings), formula factors, age at retirement and selected annuity option or a money purchase option. Regular employees working at least 1200 hours a year (600 hours for employees covered prior to 7-11-11) are automatically enrolled.

- Vesting Requirements – You may have to meet one of two vesting laws in order for the City of De Pere contributions to be vested. This is based on when you first began WRS employment.
  - If you first began WRS employment after 1989 and terminated employment before April 24, 1998, then you must have some WRS creditable service in five calendar years.
  - If you first began WRS employment on or after July 1, 2011, you must have five years of WRS creditable service.
  - If neither vesting law applies, you were vested when you first began WRS employment. If you are vested, you may receive a retirement benefit at age 55 (age 50 for protective category participants) once you terminate all WRS employment. If you are not vested, you may only receive a separation benefit.

* The Employer contribution for protective employees includes the required contribution for duty disability.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Did You Know?

Your EAP (Employee Assistance Program) benefit offers easy access to professional, confidential counseling services in-person in De Pere (1881 Chicago Street, De Pere, WI 54115), as well as virtual options through an extensive affiliate network. These counseling services are provided at no cost to you as a benefit through the City of De Pere and can help with a wide variety of personal and family issues including alcoholism, drug dependency, emotional illness and other problems. Up to 6 counseling sessions per issue is available to all employees and their immediate family members. Accessing this benefit is free, voluntary and always confidential.

How Do You Access The EAP?

1. Call Aurora Health Advocate at 1-800-236-3231
2. Identify you are an employee of City of De Pere or a family member of a City of De Pere employee
3. Provide brief demographic information
4. An appointment will be arranged in a timely manner. Your benefit allows up to 6 counseling sessions per issue.

If you have any questions regarding the EAP benefit or this plan design, please contact Human Resources, or the EAP directly at 800-236-3231. For more information on your EAP benefit you may visit Aurora's website at www.aah.org/eap.

The Advocate Aurora Employee Assistance Program helps employees and families make the most of life.

When to use the Advocate Aurora EAP

Consider calling the EAP when a problem:

- Occupies too much of your time
- Interferes with normal activities
- Persists for more the 2-3 weeks

Typical concerns may include:

- Alcohol/drug abuse
- Anxiety or depression
- Balancing work & family
- Caring for aging parents
- Child/family concerns
- Divorce
- Financial pressures
- Legal issues
- Relationship issues
- Workplace stress
- Finding quality and cost-effective child care

The Advocate Aurora Employee Assistance Program offers work-life services to help employees balance their work and personal lives more effectively. These services include childcare and elder care consultation, information and referrals, educational resource assistance for K-12 and higher education, adoption information, legal consultation and mediation services, and financial consultation.

AdvocateAuroraHealth

aah.org/eap

City of De Pere
Wellness Incentive Program

The City of De Pere values your health and well-being, and we are pleased to support your wellness goals through this program.

Wellness programs can benefit you in many ways by helping you improve your health and fitness and reduce your health care costs. In addition to improving your health, wellness programs have been shown to help individuals lower their stress levels and improve well-being. This program is designed to support and reward your fitness efforts with gift card incentives, up to $150!

The Wellness Incentive Program runs from January 1st until December 31st.

Who can participate?
Benefit eligible full-time and part-time employees and their spouses can participate in the City's Wellness Incentive Program. Employees and/or spouses do not need to be enrolled on the medical plan to participate.

How does the program work?
You get to pick and choose what types of wellness activities you are interested in and earn gift cards.

Participants will receive points for things such as participating in a run/walk, getting an annual physical each year, exercising, and completing preventative screenings. A small gift card incentive is built into the program to reward you for achieving points, with benchmarks along the way. Due to the logistics of some of the City-led wellness challenges, these challenges may be offered to employees only to earn points.

Where can I find the activities to earn points?
Wellness Incentive Program information can be found on the Wellness webpage at www.deperewi.gov/wellness and the City's Friday Memo Drive (Q Drive) in the Wellness Folder. At the MSC, Wellness Forms can be found near the main copier with the other blank employee forms.

The Wellness Incentive Program Flyer provides a list of all the activities you can choose from, their point value, and gift card milestone.

Do I have to reach a Gift Certificate Milestone before submitting documentation for points?
No. You can submit points as you earn them throughout the year, once you reach a milestone, or all at once. Please note, some activities need to be submitted at the end of the activity (i.e. Wellness Challenges, Recipe). See Qualification Criteria for more information. If required, proof of participation and forms should be uploaded to your IH21 account at www.IH21wellness.com, unless otherwise specified. All points and documentation, if required, must be logged in the participant's IH21 account by January 15th of the following year (i.e. 2025 documentation must be submitted by January 15, 2026); gift certificates will be distributed shortly after.

When can I start uploading documents, joining challenges, or self-reporting activities in the new year?
Since participants have until January 15 of the following year to complete their wellness submissions, tracking and document uploads for the current year's program can begin on January 16.

WELLNESS INCENTIVE PROGRAM (continued)

A few Wellness Incentive Program highlights:

- Employees and spouses can earn points for participating in virtual wellness coaching visits with Nurse Julie Johnson. Visit www.bellin.org/cc for scheduling information.

- Employees and spouses can earn up to a $150 gift card!
  1,000 point benchmark **$25 gift card**
  2,000 point benchmark **$75 gift card**
  3,000 point benchmark **$150 gift card**

- Nutrition/Wellness Classes are worth 400 points. Attend and participate in classes regarding smoking cessation, weight loss and others. This includes the live virtual classes offered through the Coaching + Culture program. Employees enrolled on the medical plan can participate in RealAppeal, an online weight loss program, at no additional cost.

- You and your immediate family members (spouse and children) will receive 25% off De Pere Park and Recreation exercise and movement-based programs. To receive the discount you will have to register either over the phone or in person at the Community Center. If you have questions on which classes may be included, please call the Community Center at 920-339-4097.

- Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all benefit eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. If you have questions or concerns, please contact the City's Human Resources Director, Shannon Metzler at 920-339-4045, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

- The City of De Pere has two onsite exercise facilities that employees can access 24/7. Facilities are available during non-work/non-paid hours.
  - **Municipal Service Center (MSC):** The exercise room is located in the basement of the MSC and has a variety of equipment, hand weights, squat rack, benches, and much more.
  - **City Hall:** The exercise room is located in the basement of City Hall and has hand weights, yoga mats, exercise balls, an elliptical, an exercise bike, and an arc trainer.
  - Spouses are also able to access the exercise facility while the employee is using it. Please be sure you, and your spouse if applicable, have a signed waiver on file with Human Resources prior to using the facilities. Waiver forms are available at www.deperewi.gov/hrforms.

If you have questions about the Wellness Incentive Program, please reach out to your department's Wellness Team member or Tracy Hood in Human Resources.

MSC: Carrie Glime and Alli Hummel
Community Center: Cindy Lee and Sue Planert
City Hall 1st Floor: Danielle Jauquet and Jessie Paque
City Hall 2nd Floor: Kevin Clark
Police Department: Corey Rodewald
Fire Department: Lea Taylor and Jesse Belleau
All: Tracy Hood

WELLNESS INCENTIVE PROGRAM (continued)

The City of De Pere presents the 2025 Wellness Incentive Program! Your health is important to us. In the coming 12 months, we challenge you to make healthy choices, have screenings, exercise and increase your wellness knowledge. Making the effort to be healthy can pay off in so many ways! The Wellness Incentive Program runs from January 1st until December 31st.

The chart below provides an at-a-glance listing of point earning opportunities as well as a very brief overview of what is required – documentation, self-reporting, or joining a challenge.

- Specific information on what documentation should be submitted can be found in the Wellness Incentive Program guide.
- Step by step instructions on how to submit documentation, join a challenge or self-report an activity, and the activity screening completion form are available on the Wellness webpage, www.deperwi.gov/wellness.

	Points Each	Points Total	How to get credit in IH21
Annual Physical	200	200	Submit documentation
Dental Exam	200	200	Submit documentation
Annual Preventive Care *(max of 3, limit 1 type of exam)* *-Eye Exam* *- Mammogram* *-Flu Shot* *-COVID Vaccination/Booster* *-Colonoscopy* *-Prostate-Specific Antigen (PSA) Test*	200	600	Submit documentation
Wellness Challenges *(max of 4)*	200	800	Submitted by Nurse
Monthly Activity Challenge	50	600	Accept monthly challenges and track your participation for each month that you completed the activity challenge.
Nutrition/Wellness Classes *(max of 2)*	400	800	Submit documentation; if completed through the Coaching & Culture program, the Nurse will submit
Charity / Community Walk *(max of 4)*	100	400	Self-report
Educational Seminar *(max of 4)*	50	200	Self-report
Monthly Exercise Challenge (min. of 30 minutes each time) 15x / month	100 / month	1,200	Accept challenge and track participation for each month that you completed the challenge.
CPR/AED Certified	50	50	Submit documentation
Donate Blood	100	200	Self-report
Wellness Champion	50	50	Submit activity screening completion form
Volunteer Work	50	50	Self-report
Community Involvement	10	50	Self-report
1:1 Health Coaching *(max of 4)*	50	200	Submitted by Nurse
Healthy Recipe	50	50	Submitted by Wellness Team
On Demand Coaching & Culture Programming *(max of 2)*	200	400	Submitted by Nurse

Your Goal: Accumulate as many points as possible (while maintaining your health)

How to Get Points:
Complete any of the listed activities and record activity completion in your IH21 account; please note, some activities do require documentation.

PRIZES!

1,000 point benchmark **$25 gift card**
2,000 point benchmark **$75 gift card**
3,000 point benchmark **$150 gift card**

3,000 + points:
Entry into a raffle for a chance to win a gift card

Gift certificates are typically distributed in February following the completion of the program.

COACHING + CULTURE PROGRAM

Wellness Coaching Services for You

What Is Wellness Coaching?

Wellness coaching meets you where you are on your journey. During a 1:1 session you'll talk obstacles and goals in your personal and professional life.

Wellness Coaching can help you:

- Take charge of your life
- Guide you in setting goals and building confidence to achieve those goals
- Strengthen emotional skills to help you overcome personal obstacles
- Identify your support team
- Inspire and challenge you to go beyond what you may typically face alone

Julie Johnson, LPN
Health Coach

PLUS - You'll receive access to live/on-demand classes, invites to special events and more powered by our wellbeing experts.

1:1 Coaching Availability

Monday & Wednesday
11:30am - 8:00pm
Tuesday & Thursday
5:00am - 1:30pm
Friday
6:00am - 2:30pm

To register for challenges and live classes, email: coachingandculture@bellin.org

SCAN ME

SCHEDULE NOW

To learn more about the programs and to register for 1:1 Coaching; go to **bellin.org/cc** or call **800.528.7883**.

bellinhealth | Lifesaver Wellbeing Series
Coaching + Culture Package

Average cost based on Wellcoaches school of coaching.

COACHING + CULTURE PROGRAM (continued)

Coaching + Culture Program

City of De Pere Employees and Spouses

Welcome City of De Pere employees and spouses to the Coaching + Culture program. This FREE offering provides a wide range of tools to support you in enhancing your overall wellbeing.

Our materials are tailored to cater to your diverse needs, covering topics such as self-care, sleep guidance, stress management, and more. This innovative approach to employee wellness is set to make a significant impact.

Coaching + Culture Package Includes:

- Personalized health coaching via video or phone.
- Live online wellbeing classes on various topics, ranging from 6 to 12 weeks, offered throughout the year.
- An on-demand wellbeing platform for convenient access to videos and activities.

  Programs currently available to earn points include:

  – Mental Health Moments
  – Beat the Pack
  – Big Little Things
  – Get Healthy, Get Moving
  – *Stay tuned for access to more programs in the near future*

Bellin Health Coach Support:

Our program offers unlimited health and wellness coaching with flexible scheduling to accommodate different work shifts. Employees and spouses can seek assistance with health and wellbeing at any time. Our Health and Wellness Coach provides personalized advice on nutrition, exercise, and emotional health to address your specific concerns.

Earning Wellness Points:

Upon completing any of the challenges, programs, or classes, Bellin will submit participant lists for wellness points.

Accessing the Program:

Visit **bellin.org/cc** or scan the QR code to schedule a 1:1 Coaching Session or register for a Live Group Class, participate in a Wellness Challenge or On-Demand Program, and for additional resources.

Take advantage of this opportunity to improve your well-being and earn wellness incentives through the Coaching + Culture program at Bellin Health.

Scan now to learn about the program and register

bellinhealth | Lifesaver Wellbeing Series Coaching + Culture Package | DE PERE

MEDICAL

NEAR SITE SERVICES

The City of De Pere has partnered with Prevea Health and Bellin Health to provide our health plan participants select services for ***FREE*** at most area locations.

- **Prevea** - All plan participants will receive a separate insurance card called "Prevea Partnered Health Access" card which must be provided by the members at the time of check-in. If the member fails to inform the front desk of the provider at the time of service, the appointment will be processed under the City's insurance plan and the member may be responsible for paying costs such as: copay/deductible/co-insurance for non-preventative services.

- **Bellin –** Near site service eligibility is automatically verified by Bellin.

FREE NEAR SITE HEALTH SERVICES

Primary Care Services

Includes Family Medicine, Internal Medicine and Pediatrics

- Preventative and Non-Preventative (i.e. diagnostic services) care
- Includes most labs and routine vaccinations (excludes travel medicine)
- X-ray and other imaging not included

Physical and Occupational Therapy (Examples Include)

- Manual therapy
- Chronic Pain and muscle or joint discomfort throughout body
- Headaches, jaw pain and dizziness
- Range-of-motion, flexibility, balance and strength training
- Pre-and post-surgical therapy
- Posture and body mechanics training
- Blood flow restriction
- Dry needling
- Ergonomic and gait assessments
- Injury prevention

Urgent Care

- Acute minor strain or injury
- Treats a variety of illnesses and injuries including colds, flu, ear infection, etc.

FastCare (Available with Bellin Only)

- Treats a variety of illnesses and injuries including colds, flu, cuts, fractures, and sprains

*These services that are processed under this benefit will be billed directly to the City of De Pere. Plan members will not receive an EOB from the insurance company, but may see Bellin visits billed at $0 when they log into their UMR account. Members will not receive a bill from either Bellin or Prevea for covered services.

Appointments may be made by scheduling online at Bellin.org/cityofdepere or Prevea.com/pph or by calling.

MEDICAL (continued)

CHOOSE THE RIGHT HEALTH CARE SETTING

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. The chart below can help you select the right setting for your needs.

TYPE OF CARE		WAIT TIME	COST (BASED ON IN-NETWORK SERVICES)
	**Near Site Services** The City of De Pere has partnered with **Prevea Health** and **Bellin Health** to provide health plan participants select services for free at most area locations. **When to go** • Primary Care Services o Preventative and Non-Preventative (i.e. diagnostic services) care o Includes most labs and routine vaccinations o X-ray and other imaging **not** included • Physical and Occupational Therapy	**1-3 days** or less, on average	***FREE***
	**Teladoc** 24/7 access to talk to a doctor via phone or video, saving you time and money when you need care. **When to go** • Sore Throat • Cough • Sinus Infection • Skin Rash • Eye Infection • Earache • Urinary Tract Infection • Aches and Pains • General Medicine • Dermatology	**15 minutes** or less, on average	***FREE***
	**Walk-In Retail Health Clinics** Retail clinics, sometimes called convenient care clinics, are located in retail stores, supermarkets and pharmacies. **When to go** • Colds or flu • Sinus infections • Allergies • Vaccinations or screenings • Minor sprains, burns or rashes • Headaches or sore throats	**15 minutes** or less, on average	**$0** Copay at Bellin FastCare **$5** Copay
	**Urgent Care** Urgent care centers, sometimes called walk-in clinics, are often open in the evenings and on weekends. **When to go** • Sprains and strains • Mild asthma attacks • Sore throats • Minor broken bones or cuts • Minor infections or rashes • Earaches	**20-30 minutes** Approximate wait time	**$0** Copay at Bellin or Prevea Urgent Care **$40** Copay any other location

MEDICAL (continued)

CHOOSE THE RIGHT HEALTH CARE SETTING (continued)

Clinical Care (your doctor's office)

Seeing your doctor is important. Your doctor knows your medical history and any ongoing health conditions.

When to go

- Preventative services and vaccinations
- Medical problems or symptoms that are not an immediate, serious threat to your health or life

1 week or more
Approximate wait time for an appointment

$0
Prevea or Bellin Near Site Services and preventative care at any location

$20
Primary Care Physician Copay

$40
Specialist Copay

Emergency Room (ER)

Visit the ER only if you are badly hurt. If you are not seriously ill or hurt, you could wait hours and your health plan may not cover non-emergency ER visits.

When to go

- Sudden change in vision
- Sudden weakness or trouble talking
- Large, open wounds
- Difficulty breathing
- Severe head injury
- Heavy bleeding
- Spinal injuries
- Chest pain
- Major burns
- Major broken bones

3 to 12 hours
Approximate wait time for non-critical cases

$200
Copay

+

Deductible & Coinsurance

City of De Pere WISCONSIN

Routine Vision and Refraction Exams are covered at 100% under the Medical Plan.

(with a frequency of one exam every calendar year)

***Note**: A contact lens examination is not considered a routine exam, therefore, the member will be responsible for the contact lens portion of the exam.*

- **Visit www.umr.com to find a participating provider**
  - *Click on "Find a Provider"*
  - *Enter "United Healthcare Choice Plus"*
  - *Click on "View Providers"*
  - *Click on "Change Location" and enter location information to search area providers.*
    - *If searching by provider name, you must enter the correct zip code of the provider then enter provider*
    - *If searching for a provider near you , enter member zip code, select mile radius willing to travel, select provider specialty Optometrist/Ophthalmologist.*
  - *Enter search criteria i.e. location, provider's name, type of service and click "search"*
- **Out of Network routine vision is not a covered benefit under the medical plan.**
- **If you have questions on your benefits or need assistance in filing a claim, please contact your UMR Customer Care specialist at 1-800-826-9781.**

The Importance of Routine Vision Care

- Good visual health plays an extremely important role in contributing to overall health.
- Periodic eye examinations are an important part of routine preventive healthcare.
- Many eye and vision conditions have no obvious symptoms.
- Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.
- Vision care is essential to maintaining a healthy lifestyle. Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis and rheumatoid arthritis.

** This is a sample list of services and is not intended to be all-inclusive.*

*** Costs are averages only and not tied to a specific condition or treatment. Out-of-pocket costs will vary based on your medical plan design.*

Teladoc® HEALTH | Made available by: City of De Pere

AVAILABLE NOW

You've got Teladoc Health
Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to get care for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account
Use your phone, the app, or the website to create an account and complete your medical history

Get Care
Request a time and a Teladoc Health provider will contact you

Feel better
The provider will diagnose symptoms and send a prescription if necessary

Get care now for free

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

Refer to your employee booklet at umr.com for Teladoc benefits

*Teladoc Health is not available internationally.

311607

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Teladoc® HEALTH | Made available by: City of De Pere

Healthy skin made easier

Personalized treatment plans for skin conditions by app or online

Dealing with a rash, acne, eczema or another skin issue? Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less.

Please note

Our Dermatology service uses images only. Communication with the dermatologist takes place through the message center.

Here's how it works:

1. Upload images of your skin condition with a detailed description.
2. A dermatologist will review and provide a custom treatment plan in 24 hours or less with a prescription if needed.
3. Ask follow-up questions through the secure message center at no charge for up to 7 days.

Get healthier skin for free/visit.

Visit Teladoc.com

Call 1-800-TELADOC (800-835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

*Teladoc Health is not available internationally.

311607

TM-DRM-10ES-F23-1_4096104_F_0623

Teladoc HEALTH

Made available by:
City of De Pere

Start feeling like yourself again

Discover how Teladoc Health Mental Health can help

Talk to a licensed mental health expert of your choice by phone or video, 7 days a week, from the privacy of your home.

Get help for:

- Anxiety and depression
- Negative thought patterns
- Sleep issues
- Relationship conflicts
- Trauma and PTSD
- Medication management (psychiatry only)

Start making progress:

1. Register and fill out a brief medical history
2. Choose the mental health expert who's right for you
3. Schedule a visit for a day and time that fits your schedule

Get started today for free

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

Refer to your employee booklet at umr.com for Teladoc benefits

Teladoc Health does not provide psychiatric services or mental health medication management to adolescents.
For the most current pricing of your Teladoc Health services, please log in to your Teladoc Health account.

311607

TM-MHT-10E-L23-01_700593688_07072021

Real Appeal®

Get support to build healthier habits

Now's a great time to start taking small steps for lasting change, with Real Appeal®. This online weight management program is designed to help you create a healthier lifestyle that you can maintain with confidence.

More support for more confidence

Real Appeal supports you every step of the way. It's available to you at no additional cost as part of your benefits.

Supportive coaching and sessions
Get personalized guidance from a coach, who leads collaborative weekly group sessions.

Making behavior change possible
Together, we'll address topics like emotional eating, mindset and motivation, and more.

Resources to stay motivated
Your Success Kit gives you access to online fitness classes, scales, a portion plate, and more.

Have your health insurance ID card handy when enrolling

Here's what you need to register:

Your calendar
Choose a weekly online session day and time that works for you.

Your shipping address
You'll receive your Success Kit after attending your first online session.

Your health insurance
Have your health insurance ID card handy when enrolling.

Get started now at enroll.realappeal.com or scan the QR code.

SCAN ME

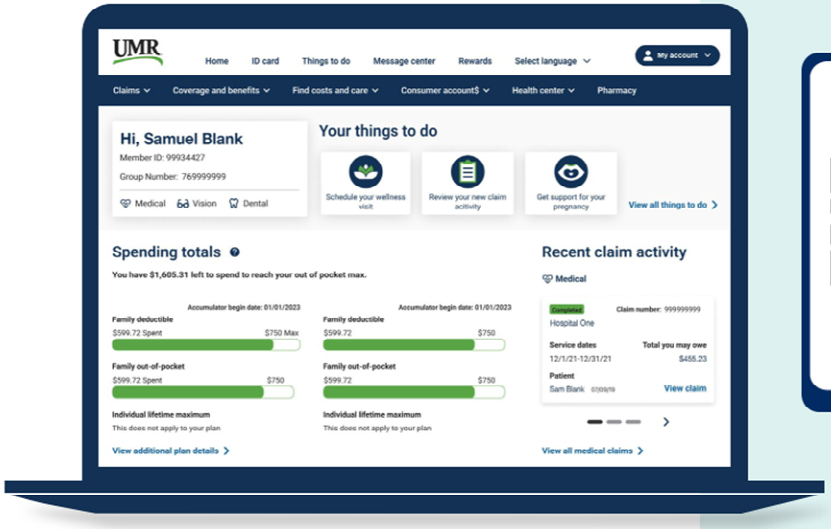
Get all your answers quick and easy at umr.com

UMR
A UnitedHealthcare Company

Make umr.com your first stop

You want managing your health care to be fast and easy, right? You got it. At **umr.com**, you'll find everything you want to know – and need to do – as soon as you sign in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!



(Fictionalized data)

Sign in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

The UMR app is another way we're reimagining health care to work for you.

We have a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.

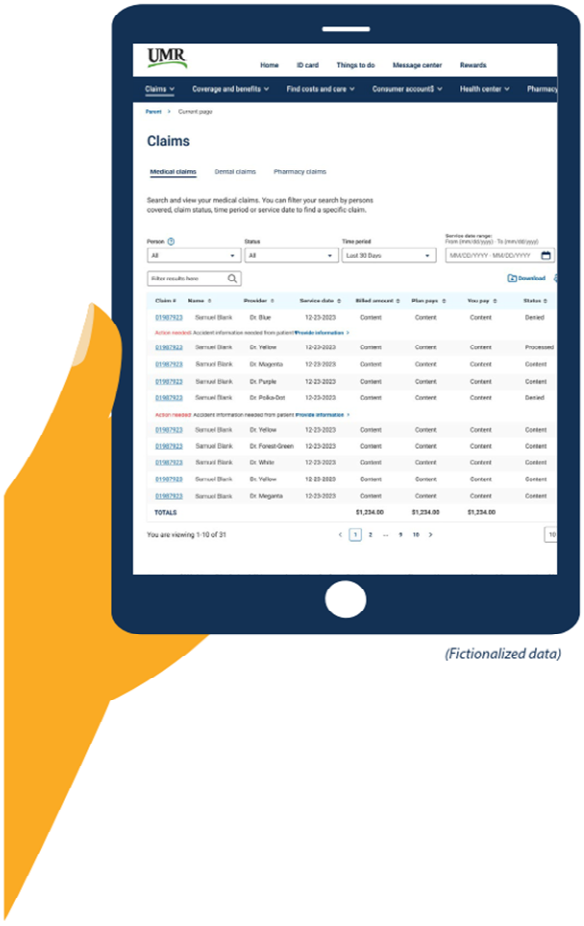
Download the UMR app today!

Scan the QR code to the left or visit your app store to get started.

With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand – anytime, anywhere
- Find out if there is a copay for your upcoming appointment
- Chat, call or message UMR's member support team

Note: The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.



(Fictionalized data)

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Select **Coverage and benefits** from the blue secondary navigation to find out:

- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a copayment for your office visit? If so, how much?

Buried in paperwork? A single click lets you track all your claims

With the **Claims** menu option, check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, select the **Claim #** or the **EOB** link on the same row as the claim. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure email any time you have a new EOB. If you're not ready to give up paper completely, you can print out copies from the **Claims** dashboard.

Don't be surprised by unexpected costs

Under the **Find costs and care** menu option, you can find in-network doctors near you and get a better idea of what you'll pay with the **Health cost estimator** tool.

UMR
A UnitedHealthcare Company

UMR
A UnitedHealthcare Company

Looking for a health care provider?

Compare quality and costs before you go

The next time you're in the market for a new doctor or are wondering how much you'll pay for a possible medical procedure, visit **umr.com** first. Your online services make it easy to look up UnitedHealthcare network providers and health care facilities and find cost estimates for different services – all in one place.

You'll get the information you need to make the right choices for you and your family and know what to expect before making an appointment.

Stay in-network

With **umr.com**, you have anytime access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket. And when you go to a network provider for preventive services, there's typically no cost to you.

You can narrow your search to primary care providers or look up physicians by specialty. Then select a physician from your search results to learn more about where they went to school, where they practice and how to schedule an appointment.

Start shopping today

Sign in to **umr.com** and select the **Find costs and care** drop-down menu. Then select **Find a provider** to search for medical providers. You can also select **Health cost estimator** to get started.

(Continued)

Check for quality

The two blue hearts next to a doctor's name tells you they are a Premium Care Provider who has been reviewed by UnitedHealthcare and meets quality standards for delivering cost-effective care.

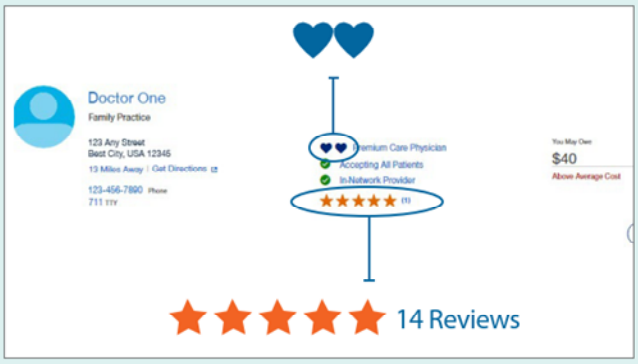
You may also see star ratings for customer satisfaction based on reviews from previous patients.

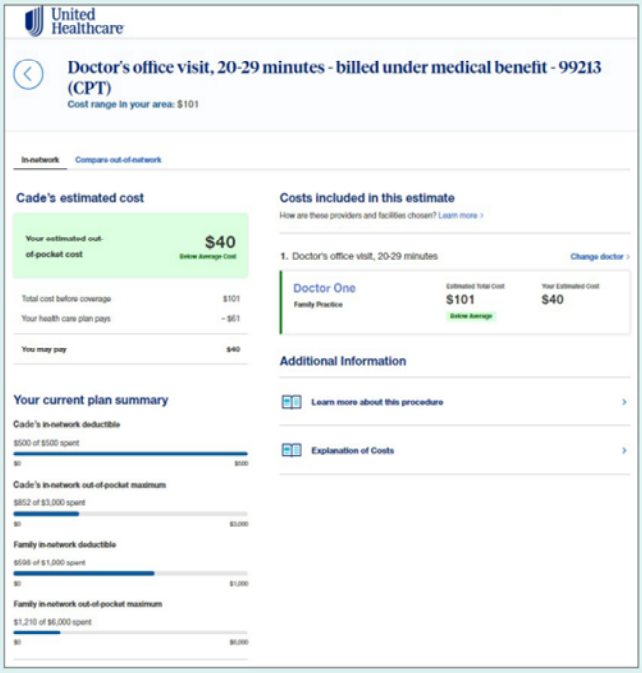
Understand the costs

Different providers may charge different amounts for the services they offer. Your search results will give you a range of the average costs for preventive care or medical procedures in your area. And the individual provider listings show whose costs are below, above, or meet the local average.

If a procedure typically includes multiple steps of treatment, you can review the total cost and your estimated out-of-pocket cost for each step. So you'll know what to expect, from start to finish.

Your estimated out-of-pocket costs are personalized to you, based on your own benefit plan's deductible, annual out-of-pocket max, copay, coinsurance and how much you've paid toward your deductible.





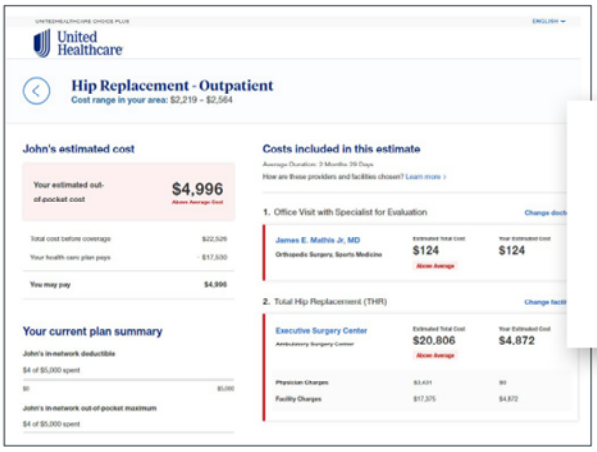
(Fictionalized data)

UMR
A UnitedHealthcare Company

How to view cost estimates using the health cost estimator:

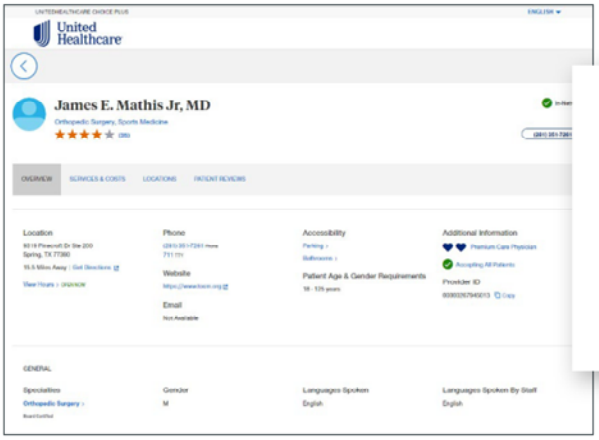
Search for a service

Find the treatment or service that applies to you by entering a search term and reviewing a list of options.



Quickly view cost estimates based on your location and the provider's network affiliation

Note that these are estimates only and should not be considered final cost estimates.



Find more information on the providers listed on your estimate

By clicking the provider's name on the previous screen, you can view details about the doctor. Look for the blue hearts for quality providers. You can also click **Change doctor** on the previous screen to see a comprehensive list of providers.

Disclaimer: This content is provided for information only and is not to be considered medical advice. All decisions about medical care should be made by the doctor and patient. Always refer to the plan document for specific benefit coverage or call the toll-free member phone number on your health plan ID card.

UMR
A UnitedHealthcare Company

Get a 90-Day Supply of Medication for the Cost of 60-Days

MAINTENANCE CHOICE

There are two ways to save on a 90-day supply of medication:

1. ***MAIL ORDER***
Register online at caremark.com/RxDelivery

OR

Call the toll-free number for CVS/Caremark on the back of your Medical ID card

- Medicine arrives in private, tamper-resistant packaging. Packaging is temperature-controlled when needed.
- Automatic refill option

2. ***CVS/TARGET or COSTCO***
90-day supplies can be purchased at your local CVS/Target or Costco pharmacy

- Same day prescription pick-up available
- Talk with a pharmacist in person

PLEASE NOTE

Because 90-day supplies are available at CVS/Target or Costco pharmacies for less, 90-day supplies will need to be obtained from those locations or through mail order.

MEDICAL (continued)

The City of De Pere Health Plan includes a benefit that allows covered members to access discounted hearing aids and related testing and fitting. This benefit is offered under the health plan by UnitedHealthcare.

UnitedHealthcare Hearing

UMR
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Because your hearing health is part of your overall health

Get the support your need to hear your best

Take charge of your hearing health today

Treating hearing loss may help you rediscover parts of your life that may have felt missing — including engaging in daily activities and staying connected to the people you love. You'll also support your long-term health and can potentially reduce the risk of diseases such as dementia.[1]

UnitedHealthcare Hearing is here to help. Through UnitedHealthcare Hearing, you'll save up to 50% off a wide selection of hearing aids and services.

1 **Contact UnitedHealthcare Hearing to schedule an initial hearing exam and consultation**

Treat hearing loss and protect your hearing health. Call **866-926-6632, TTY 711** to schedule an appointment.

2 **Your provider will help you find the perfect solution**

At your consultation and exam, your provider will assess your hearing and provide a personalized recommendation. Plus, they'll be able to answer any questions you have.

Better hearing starts here

Getting a professional hearing test is an important first step in taking care of your hearing. If you already have hearing aids, have them evaluated to make sure they're the right devices for you. Both of these services are covered at no cost by your UnitedHealthcare plan, and can help you protect your hearing as well as your overall health.

Good-to-know details

- You have 60 days to try out hearing aids purchased from a provider
- Your plan includes a three-year extended warranty for repairs and a one-time loss or damage replacement[2]
- Schedule up to three follow-up visits at no cost, with additional support available[3]
- Receive a no-cost hearing exam
- Choose from high-quality hearing aids, including Relate, Beltone, Oticon, Phonak, ReSound, Unitron, Signia, Widex, and Starkey

Get started

Call UnitedHealthcare Hearing to schedule an appointment:
866-926-6632, TTY 711

Be sure to have your hearing plan name available when you call to schedule your appointment.

Learn more about your hearing health at **uhchearing.com/employee** or by scanning the QR code.

[1] Journal of the American Medical Association. "Hearing Loss and Dementia Prevalence in Older Adults in the US."

[2] One-time professional fee may apply.

[3] Hearing aids purchased in the Silver technology level will receive one follow-up visit. Hearing aids purchased using virtual care and direct delivery receive virtual follow-up visits.

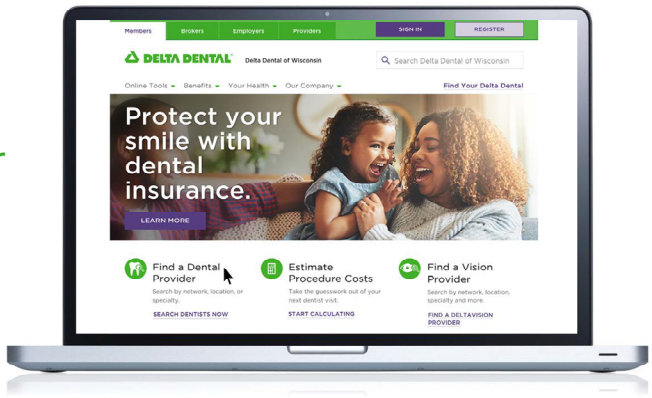
UnitedHealthcare Hearing

UMR
A UnitedHealthcare Company

DELTA DENTAL

Finding a Network Provider

A simple search tool to help make you smile.



At Delta Dental of Wisconsin, our provider directories are accessible online, via our mobile app, and by phone.

Delta Dental has more than 154,000 participating providers in our networks across the United States. In the U.S., 8 out of 10 dentists belong to a Delta Dental network.

on the web

- Go to **www.deltadentalwi.com** and select "Find A Dental Provider."
- Enter your search criteria including network type* and click the "Find Providers" button.
- You can filter your results by gender and other preferences, or search again.

by phone

Call **800-236-3712** and follow the automated instructions. Participating dentists are searched by ZIP code.

mobile app

Delta Dental's mobile app is available for smart phones and tablets using iOS (Apple) or Android. To download the app on your device, visit the App Store or Google Play and search for "Delta Dental."

- Log in to the mobile app and select "Find a Dentist."
- Choose your network* (Delta Dental PPO℠ or Delta Dental Premier®) from the dropdown menu.
- Search by address or current location.

Once you've found a dentist, save your dentist to your contacts, call to schedule a visit, or get directions to their office with the touch of your finger.

*Log in to your account at www.deltadentalwi.com to verify your plan designs and network options.

Connect With Us

www.deltadentalwi.com

SS302-1905

DELTA DENTAL (continued)

DELTA DENTAL

eyeMed

Vision Care Discount

Your Delta Dental plan comes with a Vision Discount Program add-on. Save on exams, eyewear, contacts, and even laser vision correction just for being a dental member.

Vision Discount Program	Member Benefit
Exam (with dilation as necessary)	$5 off comprehensive exam/ $5 off contact-lens exam
Complete Pair of Glasses The following discounts and fees for frames, lenses, and lens options apply only if a complete pair is purchased in the same transaction. Items purchased separately will be discounted 20% off of the retail price.	
Frames (any frame available at provider location)	35% off retail price
Single Plastic Lenses (including standard scratch coating) Single-Vision Bifocal Trifocal	Member Pays: $50 $70 $105
Lens Options UV Coating Tint (solid and gradient) Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (add-on to bifocal)	Member Pays: $15 $15 $40 $45 $65
Conventional Contact Lenses (materials only)	15% off retail price
Laser Vision Correction (LASIK or PRK)	15% off retail price or 5% off promotional price
Frequency (exams, frames, lenses, and contact lenses)	Unlimited

find a vision provider

Visit **www.deltadentalwi.com/vision** then "Search EyeMed Access Network." Or call **866-246-9041**.

www.deltadentalwi.com

DENTAL ASSOCIATES

CarePlus Dental Plans

Contact Us
Call us: 1-800-318-7007
Email us: careplus@dentalassociates.com
Visit us online: careplusdentalplans.com

Online Portal

Best-in-class portal platform with full online functionality — to better serve our members.

Member Portal

For members enrolled in benefit plans.

Functionality includes:

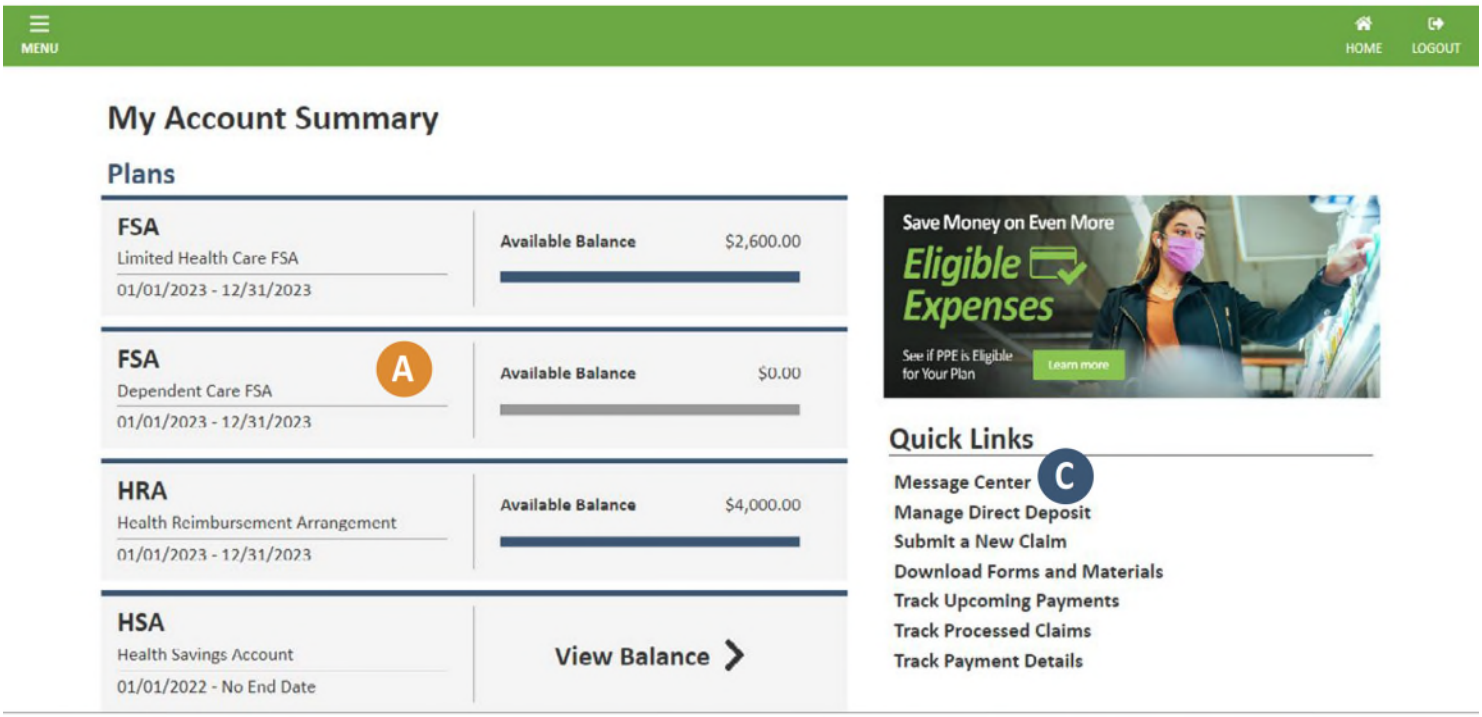
- Access personal sign on for subscribers/families - HIPAA compliant
- View member information
- Print ID card
- View benefits/benefit summary report
- View benefits used YTD (year to date)
- Find/view Explanation of Benefits (EOBs)
- View claim status
- View plan documents
- Search in-network providers
- Submit member inquiry to CarePlus
- Self-manage credential updates (username and password portal reset)

Register/Login
https://my.careplusdentalportals.com

EBC – FLEXIBLE SPENDING AND HRA

Employee Benefits Corporation

Quick Reference Guide



Any device, any time.

You can access your EBC account by logging in online or on our mobile app, ***EBC Mobile***.

Accessing Your Account

Online

To log in to your online account, go to www.ebcflex.com and log in as a participant.

Mobile

To log in to EBC Mobile, download the app from the App Store or Google Play and enter your login information.

If you don't have an account set up, you can create your account online or on EBC Mobile by selecting ***Register*** on the login screen.

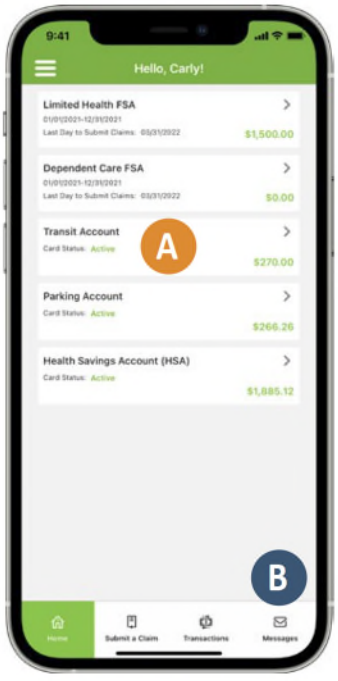
Account Overview

Home

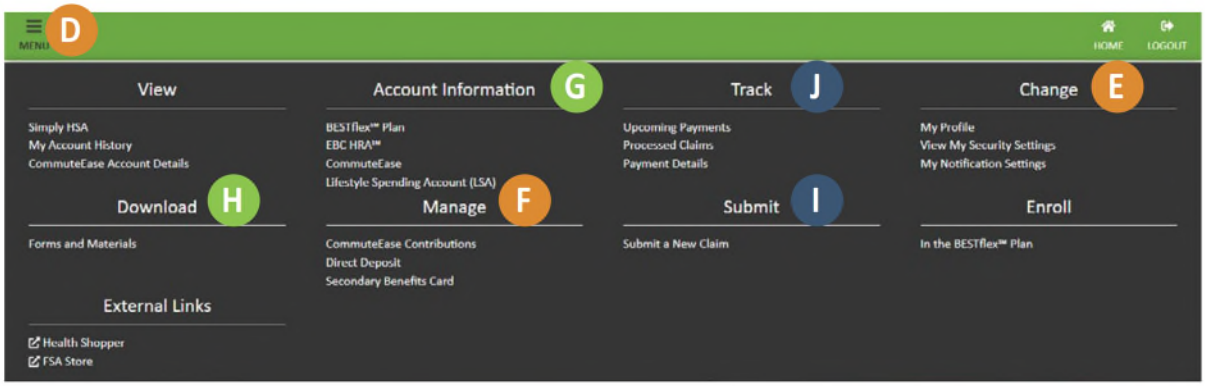
When you log in to your EBC account, you will be taken to the home screen where you can find an overview of your EBC accounts. Click each account tile [A] to access your account details.

Account Notifications

You can access important messages by selecting ***Messages*** [B] in the app or ***Message Center*** [C] in your online account.



EBC – FLEXIBLE SPENDING AND HRA (continued)



Account Settings

Navigate to the ***Menu*** **[D]** to see the following account settings.

My Profile

It's important to keep your contact information up-to-date to receive important messages from us. You can view and/or update your contact information under ***Change*** **[E]** > ***My Profile***.

Username and Password Management*

If you have forgotten your password and would like to reset it, you can do so from the login screen. If you'd like to update your username and password, go to ***Change*** **[E]** > ***View My Security Settings*** in your online account and navigate to ***User Security Settings***.

Direct Deposit*

You can sign up for direct deposit in your online account. When you sign up for direct deposit, you get your money faster because your reimbursement funds will be deposited electronically and securely in your checking or savings account. Go to ***Manage*** **[F]** > ***Direct Deposit***.

Resources

Navigate to the menu to see the following resources.

Account Information*

Find additional information in the online main menu under ***Account Information*** **[G]**.

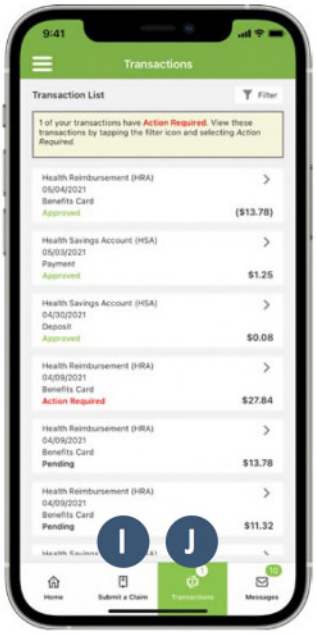
Forms and Materials*

Forms and additional materials can be found under ***Download*** **[H]** > ***Forms and Materials*** in your online account. Once you navigate to ***Forms and Materials***, you will have to choose which account you'd like to see materials for.

Some commonly accessed materials include the *Participant Authorization Form, Letter of Medical Necessity, Contract on File,* and *Eligible Expense List. Note that these documents are examples and are not available for all accounts.*

Claim Submission and Tracking

You can submit **[I]** and track **[J]** the status of your claims. Select each claim to view the full details. If you experience a denied claim, selecting the claim will provide the reason for the claim denial.



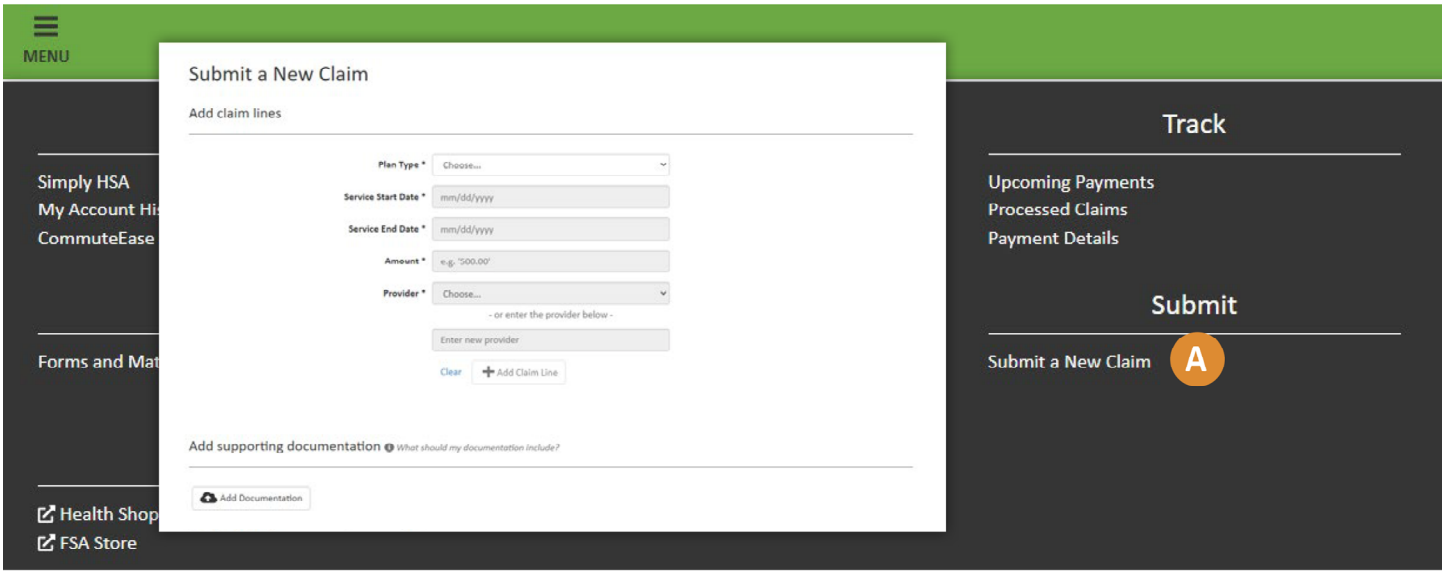
Employee Benefits Corporation

An employee-owned company
www.ebcflex.com

*The following is not available on EBC Mobile.

Employee Benefits Corporation

Submitting Claims



Any device, any time.

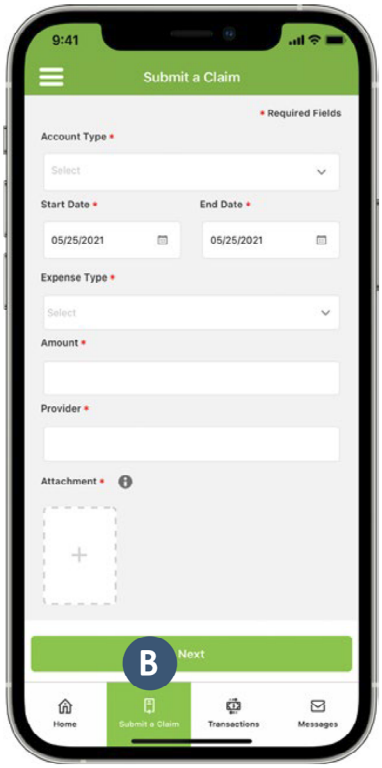
Submitting your claims online or through the EBC Mobile app helps you better manage your claims at home or on the go. If you don't have an account set up, you can create your account online or on EBC Mobile by selecting ***Register*** on the login screen.

Submitting Claims Online

1. Visit **www.ebcflex.com** and log in as a participant.
2. Select ***Submit a New Claim*** **[A]** in the menu and enter your claim information.
3. Attach the required documentation to your claim.
4. Review and submit your claim information and documentation.

Submitting Claims with EBC Mobile

1. Login to your EBC Mobile account. If you don't have the EBC Mobile app, you can download it from the **App Store** or **Google Play**.
2. Select ***Submit a Claim*** **[B]** at the bottom of your screen and enter your claim information.
3. Attach the required documentation to your claim.
4. Review and submit your claim information and documentation.



The BESTflex℠ Plan

The Benefits Card

Contents

 1014-19 06/16 Standard

Debit your BESTflex℠ Plan FSA directly instead of paying out-of-pocket.

With the BESTflex℠ Plan, you set aside money from your paycheck and place it in a Health Care Flexible Spending Account (FSA) to pay for certain medical expenses before taxes are taken from your pay.

You use the Employee Benefits Corporation Benefits Card to pay for those expenses instead of using cash. The card debits your FSA and makes the BESTflex Plan even more convenient to use.

How the Benefits Card Works

The Benefits Card debits your BESTflex Plan Health Care FSA when you use the card to pay for eligible health care expenses. For example, if your total Health Care FSA election is $1,000, the card can pay for up to $1,000 worth of eligible health care expenses.

IRS Regulations that Dictate Benefits Card Use

There are several IRS regulations that dictate how the Benefits Card works. Taking some time today to understand the most important rules will help you use your card in the most convenient ways during the plan year.

Remember to ask for and **SAVE** itemized expense documentation when you use your Benefits Card!

Eligible Expenses
You can use your Benefits Card to pay for the same services and eligible health care expenses that qualify under the BESTflex Plan Health Care FSA instead of paying out-of-pocket.

Where You Can Use Your Benefits Card
You can use the card to pay for these expenses at retailers and pharmacies that automatically substantiate the purchase at the point of sale using an inventory information approval system (IIAS). The IIAS determines whether expenses are FSA-eligible, and only applies those expenses to the card.

The growing "List of IIAS Retailers" and a store locator are available at www.ebcflex.com to help you determine whether the card will work at your preferred merchants. If a retailer cannot substantiate the purchase at the point of sale, your card will be declined.

As always, contact our Participant Services Team via email at participantservices@ebcflex.com or call 800 346 2126 to help determine if a merchant or item is eligible.

You can also use the card at health care, dental and vision provider offices. Transactions at these merchants may require that you submit expense documentation to manually substantiate the transaction.

What To Do With Benefits Card Expense Documentation
Save your Benefits Card expense documentation! If your purchase is not substantiated at the point of sale, you will receive a **Documentation Request** asking you to submit **itemized** expense documentation. The documentation allows us to verify that you used the card to pay for an eligible expense, as required by the IRS.

These are federal mandates and the IRS provides no exceptions.

You CANNOT use your Benefits Card to pay for an expense that is already covered by your health insurance. Before you pay a doctor's bill or other such expense, check your Explanation of Benefits, sent to you by your health insurance plan, to be sure that it won't be covering that bill. You can use your card to pay for the portion of the expense that isn't covered.

Over-the-Counter Medicines
The Health Care FSA only reimburses over-the-counter (OTC) medicine expenses with a doctor's prescription for them.

In order to use your card to pay for OTC medicines, you must present your doctor's prescription to the pharmacist, and the pharmacist must fill the OTC medicine in accordance with applicable law and assign a prescription number.

You can use your card as normal to purchase OTC items that are not considered a drug or a medicine, such as bandages, contact lens solution, heating pads, ice packs, reading glasses and thermometers. You will also be able to use your card to pay for insulin and diabetic supplies.

Please reference the *Eligible Expenses List* for more information.

Retailers that Can Accept the Benefits Card
The Benefits Card will not be accepted at retailers that qualify under the "90% rule." These merchants could verify that 90% of their annual revenue is generated by FSA-eligible items.

This means that your card may be declined at a local pharmacy. Reference the "List of IIAS Retailers" at www.ebcflex.com to determine whether your card will work at your preferred merchants.

■ How You Receive Your Benefits Card
Your employer has made the Benefits Card part of your BESTflex Plan Health Care FSA. You elect the card by electing the Health Care FSA or completing a special election form.

Once you enroll in the BESTflex Plan Health Care FSA, the Benefits Card is mailed directly to your home. The envelope will contain your card, a cardholder agreement and an information flyer. Watch for it to arrive within 30 days after your plan start date.

■ New Plan Year, Same Benefits Card
If your employer has signed up for the BESTflex Plan and the Benefits Card and you've used your card this year, your new elections will be automatically available on your card at the beginning of your new plan year. As long as your employer continues the BESTflex Plan, you'll receive a new card 30 days prior to your card expiration date.

■ Cut-Off Dates for Using the Card
If your employer has added the 2-1/2 month grace period to your BESTflex Plan, you can use your card to pay for expenses that you incur during the grace period. Otherwise, once your grace period ends, you can no longer use the card for previous plan year expenses.

3 things you should understand ***before*** you use your Benefits Card:

1. You may be asked to document your Benefits Card purchases by providing itemized expense documentation.
2. ***Do not submit documentation until it is requested.*** We'll send you a list of card transactions that were not substantiated at the point of sale, which you return to us with a copy of your documentation.
3. You will be asked to and must repay the expense amount if you make a purchase with the card and, upon request, cannot provide itemized expense documentation for the expense for any reason.

You have 90 days after the plan year ends to submit reimbursement requests for expenses incurred during the previous plan year. See your BESTflex Plan *Summary Plan Description* for more information on the 90-day run-out period.

Note: Please consult My Company Plan for the specific details defining your company's plan design.

Using the Benefits Card to Pay for End-of-Year Expenses

You can use the card to pay for items equal to the amount remaining in your BESTflex Plan Health Care FSA and pay for the difference through some other means. Toward the end of the year, frequently check your remaining FSA balance on our website, www.ebcflex.com, or by calling Employee Benefits Corporation at 800 346 2126. It is important to make sure sufficient funds are available to handle the purchases you plan to make at year's end.

Keeping Your Card Active When Your Address or Name Changes

Be sure to update your address with your employer and with Employee Benefits Corporation when you move or your card will be declined at any merchant that uses an address verification process. Address changes can be made online through My Account Assistant.

You should also be sure to update your employer and Employee Benefits Corporation if you have a name change. Changes to your last name will result in a new card being issued to you and a fee paid from your Health Care FSA.

Documentation Requests

Whenever possible, your card tries to electronically verify your purchase at the cash register. However, some card swipes require itemized expense documentation to be submitted in order to verify the transaction. Documentation Requests are sent via email and used to collect your documentation and substantiate the expense. When the card cannot verify a claim electronically or at the cash register:

1. We send you a Documentation Request email outlining the unverified expenses.
2. You upload your documentation to us using our mobile app or from your online account.
3. You can also print and return the tear-off portion of the Request to us via fax or U.S. Mail with copies of your expense documentation for the specified expenses.

If we do not have a valid email address, we will send the Requests via U.S. Mail (this may cause delays in processing your documentation).

How Documentation Requests will be sent:	
With Email on file	***No Email on file***
First Notice via email	First Notice via U.S. Mail
Second Notice via email	Second Notice via U.S. Mail
Suspension Notice via U.S. Mail	Suspension Notice via U.S. Mail

If there is no response to the first Request (First Notice), a second Request will be sent to the same email or the same U.S. Mail address (Second Notice). If there is no response to the second Request, you'll receive a letter via U.S. Mail notifying you that your card is suspended (Suspension Notice).

Expense documentation must include:

A. Date(s) of Service

B. Type of expense

C. Amount of the expense incurred

D. Name of Service Provider

Note: Cancelled checks, credit card statements or previous balance statements cannot be used as expense documentation.

Please, do not submit Benefits Card expense documentation attached to a *Claim Form*. Do not send in expense documentation unless you receive the Documentation Request.

Receiving Documentation Requests via Email

If you activated your account at our website (www.ebcflex.com) and currently view your account online, we have the email address you provided at that time. This is the email address we will use unless you change it using My Account Assistant or contact us and request that we change it. Log in to update your email preferences.

Benefits Card Suspensions

Suspension usually occurs because of outstanding, unsubstantiated expenses made using the card. You can request any outstanding Documentation Request. If you cannot supply valid, itemized expense documentation, you must repay the plan.

If your card privileges have been suspended and your employer renews your plan, your card will not be reinstated until you send in valid documentation for the outstanding expenses or repay the plan.

When Expense Documentation May Not Be Required

There are two instances where documentation may not be required. Although your expense information is submitted automatically in these situations, it is still important that you save your expense documentation in case of a data transfer problem or other error. You should not be asked to submit documentation:

1. When you use your card at your health care provider for an office or prescription co-pay, and the card expense item exactly matches the co-pay item cost your employer has on file with us.
2. As long as you purchase eligible prescriptions, medical supplies or contact lens supplies from retailers that can automatically substantiate your card transactions at the point of sale through an IIAS. We have a full "List of IIAS Retailers" available on our website, www.ebcflex.com.

Remember this simple rule: if the provider cannot substantiate the expense at the point of sale, we are required to request documentation to verify the entire transaction.

If you cannot verify the transaction with expense documentation or you used the card to pay for an ineligible expense, you are asked to repay the plan or your card will be temporarily suspended until payment is received.

Terminating Employment and the Card

Your Benefits Card will be closed if you terminate employment with the employer that offers the card. To submit claims during your run-out period after termination, you must use a *Claim Form*.

Contact Employee Benefits Corporation

If you have any questions regarding the card or any aspect of your BESTflex Plan account, please email **participantservices@ebcflex.com** or contact the Participant Services Team at **800 346 2126.**

Quick Tips for Using the Benefits Card

The card may be declined for one of a few reasons:

1. The merchant does not accept the Benefits Card. See "IRS regulations that dictate Benefits Card use".
2. The expense is not eligible under the BESTflex Plan.
3. Your card has been temporarily suspended due to an unsubstantiated or ineligible expense.

You may have to submit expense documentation for transactions from some merchants, and not from others. Many eligible merchants can automatically substantiate – or verify that the expenses paid for with the card are FSA-eligible – your transaction at the point of sale, using an IIAS. Others, including some health care providers, may not have this capability.

You will receive Documentation Requests by email if you have an email address on file. These emails are not spam messages, so be sure to watch for them. See "Documentation Requests".

Save your card, even after you use up your Health Care FSA funds or the BESTflex Plan plan year ends. You will receive a new card 30 days prior to your card expiration date. See "New plan year, same Benefits Card".

Use the card to pay for things like prescription and health plan co-payments, deductibles and co-insurance; "Amount Due" on medical and dental statements; orthodontics; vision services and eyeglasses; eligible medical supplies (bandages, ointments, rubbing alcohol, sunburn cream, contact lens solutions/supplies, crutches, blood pressure and heart rate monitors, and braces); and insulin & diabetic supplies.

Online and Mobile Benefits Card Account Management
File claims, manage Benefits Card transactions, and upload documentation online or using an Android or Apple smartphone or tablet!

If a transaction needs documentation, you will receive an email. Simply take a photo of your documentation using your mobile device's camera, attach an image from the device's photo library or from your computer's desktop and submit it to us.

Employee Benefits Corporation
We make it easy.

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

The BESTflex™ Plan

Standard Health FSA Eligible Expenses

There are two types of Health Care FSAs: a standard health FSA and a limited health FSA. Your **standard health FSA** allows you to pay for eligible medical, vision, and dental expenses that are not covered by another health plan.

Examples of **Eligible** Expenses for Standard Health FSAs:

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

Vision Expenses
- Contact Lenses, Contact Lens Solution and Cleaners
- Eye Examinations
- Eyeglasses, Reading Glasses, Prescription Sunglasses
- Laser Eye Surgeries, Radial Keratotomy/LASIK

Out-of-Pocket Uncovered Medical Care Expenses
- Copays, Coinsurance, Deductible Expenses
- Prescribed Medication *(including insulin and birth control)*
- Prescribed Vitamins

Lab Exams/Tests
- Blood Tests, Spinal Fluid Tests, Urine/Stool Analyses
- Cardiographs
- Diagnostic Fees, Laboratory Fees
- X-Rays
- At-Home COVID-19 Testing

Medical Treatments/Procedures
- Acupuncture, Chiropractor
- Hearing Exams, Hearing Aids and Batteries
- Inpatient treatment for addiction to alcohol/drugs
- Infertility, In-vitro Fertilization
- Physical Therapy, Speech Therapy
- Sterilization, Vasectomy and Vasectomy Reversals
- Vaccinations and Immunizations
- Well Baby Care

Continued →

Medical Supplies and Services

- Abdominal/Back Supports, Arch Supports/Orthopedic Insoles *(not for general comfort)* or Diabetic Shoes
- Blood Pressure Monitors
- Breast Pumps and Lactation Supplies
- Compression Hosiery above 30 mmHg
- Contraceptives, Norplant Insertion or Removal
- Counseling *(except for Marriage and Family)*
- Crutches, Wheelchair, Oxygen Equipment, Splints/Casts
- Medic Alert Bracelet or Necklace
- Hospital and Ambulance Services
- Insulin Supplies, Syringes
- Guide Dog *(for visually/hearing impaired person)*
- Mastectomy Bras, Prosthesis
- Medical Miles, Tolls, Parking, or Transportation Expenses *(essential to medical care)*
- Pregnancy Tests, Pre-Natal Vitamins

Over the Counter (OTC) Products

- Allergy, Anti-Itch, Antihistamine Medicines, Eye Drops
- Digestive Tract Relief Medications, Antacids, Anti-Diarrhea Medications, Laxatives
- Anti-Nausea Medications, Motion Sickness Pills
- Cold and Flu Medications, Cough Drops & Syrups, Decongestants, Nasal Sinus Sprays, Sore Throat Spray, Sinus Medications, Throat Lozenges, Vapor Rubs
- First Aid Creams, Diaper Rash Ointments, Calamine Lotion, Bug Bite Medication, Wart Remover Treatments, Special Ointments/Burn Ointments, Rubbing Alcohol
- Menstrual Pain and Cramp Relief Medication
- Menstrual Products, including Tampons and Pads
- Pain Relievers, Analgesics, Aspirin, Fever Reducers, Muscle/Joint Pain Relievers
- Smoking Cessation Products, Nicotine Gum/Patches
- Sunscreen with at least SPF 15
- Athletes Foot Creams and Powders, Cold Sore Remedies, Hemorrhoid Medications, Lice and Scabies Treatments, Yeast Infection Treatments

Personal Protective Equipment (PPE) to Prevent Spread of COVID-19

- Face masks (disposable or cloth), with multiple layers of material and with nose wire
- Hand sanitizer rubs and hand sanitizing wipes with at least 60% alcohol content

This list is not meant to be all inclusive. Other expenses not listed may also qualify. Please contact us if you have any questions.

Examples of *Ineligible* Expenses for Standard Health FSAs:

We're commonly asked which expenses are not eligible for payment. Here are some examples, but the list is not all inclusive.

- Canceled Appointment Fees
- Drugs or treatments that are illegal under Federal law
- Cosmetic Surgery, Treatments, or Procedures
- Toiletries or Sundry Items
- Vitamins or Supplements for General Health
- Food and meals that replace regular nutritional requirements
- Household cleaning products, including surface cleaning wipes
- Face shields, neck gaiters, or face masks with vents/valves

Personal care items or services for general health are not usually eligible, but if your health care provider recommends an otherwise personal product or service to treat a specific diagnosis, you can submit the expense for reimbursement with a *Letter of Medical Necessity.*

This is a letter from your health care provider that includes a recommendation of the item or service to treat your diagnosis, and the duration of the recommendation. Depending on the expense, you may have to provide additional documentation to show the expense would not have been incurred "but for" the medical condition.

Sometimes a personal or general use item may be specialized for the specific purpose of treating or alleviating a medical condition. In this case, only the excess cost of the specialized item over the non-specialized item can be reimbursed. A *Letter of Medical Necessity* may be requested for these items as well.

Employee Benefits Corporation

E: ParticipantServices@ebcflex.com
P: (800) 346-2126 | (608) 831-8445
An employee-owned company
www.ebcflex.com

Where can I shop?

Visit www.ebcflex.com/WheretoShop

With our large vision network, there's always a provider in sight

Finding a trustworthy provider who meets your lifestyle, eye care and eyewear needs is easier with UnitedHealthcare.

With UnitedHealthcare Vision Network, you can take advantage of personalized care at a local doctor or convenient evening and weekend hours at your favorite well-known retail chain or specialty online retailers.

Well-known practices and brands in our large national network include:

- 1-800 Contacts—including ExpressExam*
- Allegany Optical
- America's Best
- Bard Optical
- befitting.com
- Berkeley Eye Center
- Clarkson Eyecare
- Cohen's Fashion Optical
- Costco Optical
- Dr. Tavel Family Eye Care
- Eye Doctor's Optical Outlets
- Eyeglass World
- EyeMart Express
- For Eyes
- General Vision Services
- GlassesUSA.com
- Henry Ford OptimEyes
- JCPenney Optical
- LensCrafters—including lenscrafters.com
- Meijer Optical
- Midwest Vision Centers
- My Eye Lab
- MyEyeDr.
- National Vision
- Nationwide Vision
- Pearle Vision
- Rosin Eyecare
- Rx Optical
- Sam's Club
- SEE Inc.
- Shawnee Optical
- Shopko
- Stanton Optical
- Sterling Optical
- SVS Vision

Making it easier for you to find a provider

To find the provider who best meets your needs, sign in to **myuhcvision.com** or call **1-800-638-3120**.

Some providers or locations may not participate in your plan.

*For virtual prescription renewal only. ExpressExam may not be available for all vision plans and is not in all states.

continued

United Healthcare

Well-known practices and brands in our large national network include:

- Target Optical—including targetoptical.com
- Texas State Optical
- Today's Vision
- Total Vision
- Vision Source
- Visionworks
- Vista Optical
- Walmart
- Warby Parker—including warbyparker.com
- Wisconsin Vision

See more ways to save

Keep out-of-pocket costs low by visiting **uhccontacts.com** or **uhcglasses.com** where you'll have a variety of brands and frame choices at your fingertips.

Call
1-800-638-3120

Visit
myuhcvision.com

United Healthcare

The examples provided are for general knowledge purposes only and should not be interpreted as a preference or recommendation of any particular provider, brand, or company. We encourage members to choose providers based on their individual needs and preferences.

The company does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

To ask for help, please call 1-800-638-3120, TTY 711, Monday through Friday, 7 a.m. to 10 p.m. CST.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120, TTY 711.

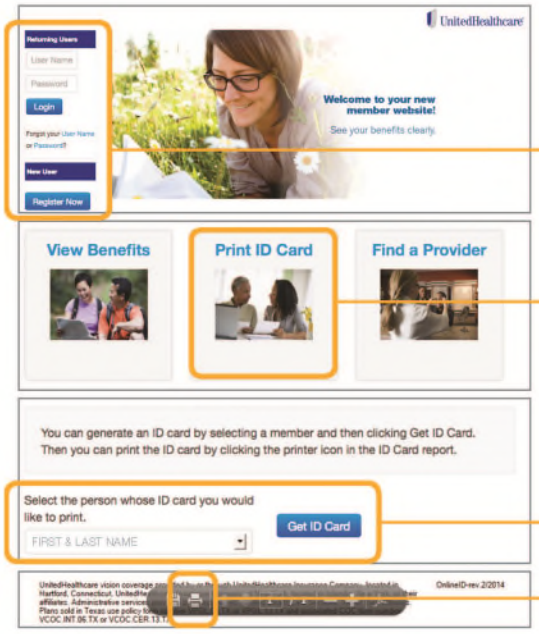
請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-800-638-3120, TTY 711。

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX , VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact the company.

How to print your vision ID card using **myuhcvision.com**

Thanks to our convenient paperless benefits and claims, **you do not need a member ID card to use your benefits**. However, if you'd like one, you can easily print one.

Your ID card will be personalized with your name, member ID, as well as your exam and materials co-pay amounts.



Steps to print your Vision ID card:

1. Go to **myuhcvision.com**
2. Log in or register. Do not register if you also have medical coverage with UnitedHealthcare.
3. Click on "Print ID Card" If you do not see this option, click on the blue "Select" button next to your plan name.
4. From the drop down menu, select the person whose ID card you would like to print. Click on "Get ID Card."
5. This generates a document with your ID card called *How to Use Your Vision Care Benefits*. Scroll to the bottom of this document. A toolbar will appear; click on the printer icon to print.

Sample Personalized ID Card

UnitedHealthcare®

Member Name: [First, Last]
Member ID: [XXXXXXXXX-XX]
Member Web: www.myuhcvision.com
Customer Service: (800) 638-3120

Vision Identification Card

fold here

Vision Care Benefits

Exam Copay: [$XX.XX]
Material Copay: [$XX.XX]

Submit Out-of-Network Claims to:
UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Note to Providers:
For more information about this UnitedHealthcare Vision plan, please visit us online at www.Spectera.com or call 1-800-638-3120.

UnitedHealthcare®

TRAVELERS

Identity Fraud Expense Reimbursement

COVERAGE HIGHLIGHTS

Why you need protection

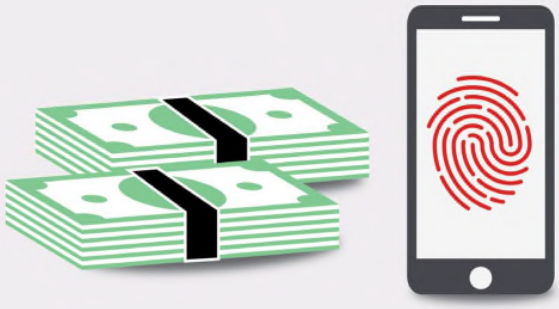
Becoming a victim of identity fraud is a frightening, frustrating experience. It can happen to anyone at any time in a variety of ways, ranging from a stolen wallet or home burglary to online theft of your personal information.

Recovering from identity fraud means more than just canceling credit cards. Not only can it be a complicated and stressful experience, but it can cost your employee or member of your organization hours of time and out-of-pocket expenses to reestablish their credit and clear their name. The hard reality is that victims must painstakingly prove, often to disbelieving creditors, that the debts are not their own. Purchasing identity fraud expense reimbursement coverage for your employees or members can be an affordable and compelling addition to your benefits suite.

Identity fraud losses in 2021 totaled

$24 billion

and affected 15 million U.S. adults.



Source: 2022 Javelin Strategy & Research

Coverage highlights

Travelers Identity Fraud Expense Reimbursement coverage helps pay for expenses associated with resolving an identity fraud event and perhaps, most importantly, gives people tools and information to reduce their risk of future additional fraud.

In addition to expense reimbursement, Travelers also has an endorsement for purchase that offers Identity Fraud Resolution Services through CyberScout®, which includes:

- Exclusive online education resources providing tips and information to help avoid becoming a victim.
- 24/7 personal access to an expert fraud specialist.
- Document replacement help (i.e., Social Security card, birth certificate, passport, etc.).

In the event of an actual identity fraud, services include:

- Step-by-step guidance through the resolution process, including unlimited assistance to restore a victim's identity.
- 3-in-1 credit reporting.
- One year of free credit, cyber and fraud monitoring.

IDENTITY FRAUD (continued)

Claim scenarios

Bogus charge accounts while on business travel

An executive was on business in Brazil when his identity was stolen and significant charges were made to his corporate card. In order to file an affidavit of loss with the local Brazilian authorities, he was required to provide a sworn statement in person. Total expenses for time off work, travel expenses, phone charges and the cost to replace the executive's passport were $4,500.

Medical identity fraud

A woman from Illinois discovered a number of questionable billings on her medical insurance annual summary of benefits. Someone had stolen her identity and her children's identities to secure medical services in their names.

After struggling with the health care institution to release the personal medical information, she hired an attorney to help. The attorney was able to contest the services and clean up her medical history. It took more than six months to resolve the identity fraud and cost nearly $6,000 in attorney's fees, lost wages and fees for copies of X-rays and other medical records.

Why Travelers?

- We've provided effective insurance solutions for more than 160 years and address the needs of a wide range of industries.
- We consistently receive high marks from independent ratings agencies for our financial strength and claims-paying ability.
- With offices nationwide, we possess national strength and local presence.
- Our dedicated underwriters and claim professionals offer extensive industry and product knowledge.

Travelers knows ID Fraud.
To learn more, talk to your independent agent or visit travelers.com.

TRAVELERS

travelers.com

Public Service Loan Forgiveness Program

Public Service Loan Forgiveness Program (PSLF)

Are you burdened by student loan debt?
The Public Service Loan Forgiveness (PSLF) may be able to help!

What is the Public Service Loan Forgiveness Program?

The Public Service Loan Forgiveness (PSLF) program is a federal initiative designed to provide financial relief to individuals working in public service jobs such as government or not-for-profit organizations. By making qualifying payments towards your federal student loans, you may be eligible for forgiveness of your remaining loan balance after 120 qualifying payments.

Benefits of the Program

Loan Forgiveness: After making 120 qualifying payments while working full-time for a qualifying employer your remaining federal student loan balance may be completely forgiven.

Flexibility in Repayment Plans: PSLF is compatible with various federal repayment plans, including Income-Driven Repayment plans.

Tax-Free Forgiveness: Unlike some other loan forgiveness programs, the amount forgiven through PSLF is not considered taxable income, providing additional financial relief.

How to Qualify

1. Employment with a Qualifying Employer: The City of De Pere is an eligible employer for the PSLF program. Working full-time for the City can help you qualify for loan forgiveness.

2. Federal Direct Loans: To be eligible, you must have federal Direct Loans. Other types of federal student loans, such as Perkins or FFEL loans, may be eligible if consolidated into a Direct Consolidation Loan.

3. Make 120 Qualifying Payments: Make sure to make 120 qualifying payments while employed by a qualifying employer. These payments must be on time and made under a qualifying repayment plan.

Next Steps

Visit StudentAid.gov/publicservice to learn more about the program, learn who is considered a qualified employer, review frequently asked questions, and more.

If you're working toward PSLF, complete and submit the *Public Service Loan Forgiveness (PSLF) & Temporary Expanded PSLF (TEPSLF) Certification & Application* annually or when you change employers. They use the information you provide to let you know if you're on the right track. You can download the form and get more info on the PSLF program at StudentAid.gov/publicservice.

Disclaimer: This flyer provides general information about the Public Service Loan Forgiveness Program. Please consult StudentAid.gov/publicservice for detailed eligibility criteria and guidance.

REQUIRED FEDERAL NOTICES

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private 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. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURNACE 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 are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our 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 self-only coverage under our health plan is more than a certain percentage of your household income for the year, or if our health plan does not meet the "minimum value"[1] standard set by the Affordable Care Act, you may be eligible for a tax credit. Please visit healthcare.gov for the annual affordability percentage or contact the employer identified on the following page of this notice.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – 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 ABOUT THE MARKETPLACE?

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

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

Marketplace Coverage Notice (continued)

Information about the Health Coverage Offered by Your Employer

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name: City of De Pere
Employer Identification Number (EIN): 39-6005431
Employer Address: 335 S Broadway, De Pere, WI 54115
Employer Phone Number: 920-339-4045
Who can we contact about employee health coverage at this job? Phone Number (if different from above): Tracy Hood

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.

- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.

- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

Women's Health And Cancer Rights Act (WHCRA) Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy- related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your UMR at 1.800.826.9781.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

CHIP (continued)

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

CHIP (continued)

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

CHIP (continued)

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

Paperwork Reduction Act Statement

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

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

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

HIPAA 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 towards 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).

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 of marriage or 60 days after birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Tracy Hood, Human Resources Generalist, at 920-339-4045.

The City of De Pere Employee Benefits Plan
Notice of Privacy Practices — Self-Funded Plans

01/01/16

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The City of De Pere offers various healthcare options to its employees and their eligible family members through the City of De Pere Employee Benefits Plan. The City of De Pere Group Health Insurance Plan, Group Dental Insurance Plan, Flexible Spending Account (FSA), Health Reimbursement Account (HRA), and Employee Assistance Plan (EAP) are self-funded group health plans for which the City of De Pere acts as its own insurer and directly pays the claims. This notice describes the privacy practices that the City of De Pere has established for this option. This option is managed for the City of De Pere by business associates, which are third-party administrators that interact with the healthcare providers and handle members' claims.

THE CITY OF DE PERE'S COMMITMENT

The City of De Pere is committed to protecting the privacy of your protected health information or PHI. PHI refers to health information that a Self-Funded Plan creates or receives that relates to your physical or mental health, your healthcare or payment for your healthcare. In most cases, your PHI is maintained by the business associate that serves as the third-party administrator for the Self-Funded Plan in which you participate, but the City of De Pere may also hold health-related information. Generally, the City of De Pere held information is limited to enrollment data, but in limited instances it may include information you provide to designated City of De Pere staff to help with coordination of benefits or resolving complaints. The privacy protections described in this notice reflect the requirements of federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). They require the Self-Funded Plans to:

- comply with HIPAA privacy standards and other federal laws;
- make sure that your PHI is protected;
- give you this notice of the Self-Funded Plans' legal duties and privacy practices with respect to your PHI; and
- follow the terms of the notice that are currently in effect.

HOW THE SELF-FUNDED PLANS WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following sections describe different ways that a Self-Funded Plan might use and disclose your PHI. Not every use or disclosure will be listed. All of the ways that a Self-Funded Plan is permitted to use and disclose PHI, however, will fall within one of the categories. Use and disclosure of some PHI, such as certain drug and alcohol information, HIV information and mental health information, is further restricted.

Treatment. A Self-Funded Plan may use and disclose your PHI to doctors, nurses, technicians and other personnel who are involved in providing you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may then tell the dietitian if you have diabetes so the dietitian can meet any special menu needs. Different departments may share your PHI so they can coordinate services you need, such as lab work, x-rays and prescriptions.

Payment. A Self-Funded Plan may use and disclose your PHI in the course of activities that involve reimbursement for healthcare, such as determination of eligibility for coverage, claims processing, billing, obtaining and payment of premium, utilization review, medical necessity determinations and pre-certifications.

Healthcare operations for a self-funded Plan. Self-Funded Plans may use and disclose your PHI to carry out business operations and to assure that all enrollees receive quality care. For example, a Self-Funded Plan may disclose your PHI to a business associate who handles claims processing or administration, data analysis, utilization review, quality assurance benefit management, practice management or referrals to specialists, or to an associate who provides legal, actuarial, accounting, consulting, data aggregation, management or financial services.

Plan sponsor. A Self-Funded Plan may disclose summary health information (that is, claims data that is stripped of most individual identifiers) to the City of De Pere in its role as plan sponsor in order to obtain bids for health insurance coverage or to facilitate modifying, amending or terminating a plan. A Self-Funded Plan may also provide the City of De Pere enrollment or disenrollment information. In addition, if you request help from the City of De Pere in coordinating your benefits or resolving a complaint, a Self-Funded Plan may disclose your PHI to designated City of De Pere staff, but no PHI may be disclosed to facilitate employment-related actions or decisions or for

matters involving other benefits or benefit plans. The City of De Pere may not further disclose any PHI that is disclosed to it hese limited instances.

As Required By law. A Self-Funded Plan will disclose your PHI if required to do so by federal, state or local law or regulation.

To Avert a Serious Threat to Health or Safety. A Self-Funded Plan may disclose your PHI when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are or were a member of the armed forces, a Self-Funded Plan may release your PHI to military command authorities as authorized or required by law. A Self-Funded Plan may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

Research. In limited circumstances, a Self-Funded Plan may use and disclose PHI for research purposes, subject to the confidentiality provisions of state and federal law.

Workers' Compensation. A Self-Funded Plan may release PHI for workers' compensation or similar programs as permitted or required by law. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities. A Self-Funded Plan may disclose PHI to governmental, licensing, auditing and accrediting agencies as authorized or required by law.

Legal Proceedings. A Self-Funded Plan may disclose PHI to courts, attorneys and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

Lawsuits and Disputes. If you are involved in a lawsuit or other legal proceeding, a Self-Funded Plan may disclose your PHI in response to a court or administrative order or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement. If authorized or required by law, a Self-Funded Plan may disclose your PHI under limited circumstances to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, or to provide information about the victim of a crime.

National Security and Intelligence Activities. If authorized or required by law, a Self-Funded Plan may release your PHI to authorized federal officials for intelligence, counterintelligence and other national security activities.

Protective Services for the United States President and others. A Self-Funded Plan may disclose your PHI to authorized federal and state officials so they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations, as authorized or required by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, a Self-Funded Plan may release your PHI to the correctional institution or law enforcement official, as authorized or required by law. This release would be necessary for the institution to provide you with healthcare to protect your health and safety or the health and safety of others or for the safety and security of the correctional institution.

REQUIRED DISCLOSURES

A Self-Funded Plan may be required to disclose your PHI to the Department of Health and Human Services if the Secretary is conducting a compliance audit.

YOUR RIGHTS

You have the following rights regarding the PHI that a Self-Funded Plan maintains about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and obtain a copy of your PHI that is maintained by or for a Self-Funded Plan. To inspect and obtain a copy of the PHI, you must submit your request in writing to the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request.

A Self-Funded Plan may deny your request to inspect and/or obtain a copy in certain limited circumstances. For example, HIPAA does not permit you to access or obtain copies of psychotherapy notes. If your request is denied, you will be informed in writing, and you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. The plan will comply with the outcome of the review.

Right to Request an Amendment. If you believe that the PHI maintained by a Self-Funded Plan is incorrect or incomplete, you may request that the plan amend the information. You have the right to request an amendment for as long as the information is kept by or for the plan. A request for an amendment should be made in writing and submitted to the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer. In addition, you must provide a reason that supports your request.

Right to an Accounting of Disclosures. You have the right to receive an accounting of disclosures, which is a list of disclosures such as those that were made of PHI about you, with the exception of certain documents including those relating to treatment, payment and healthcare operations and disclosures made to you or consistent with your authorization. To request an accounting of disclosures, you must submit your request in writing to the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates

before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, the plan may charge you for the cost of providing the list. You will be notified of any costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use and disclosure of your PHI for treatment, payment or healthcare operations, or to request a restriction on the PHI that the plan may disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. The plan is not required to agree to your request. If the plan agrees to your request, it will comply with the requested restriction unless the information is needed to provide you emergency treatment or to assist in disaster relief efforts. To request a restriction, you must submit your request in writing to the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer. Your request should state the information you want to limit; whether you want to limit the plan's use, disclosure or both; and to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that a Self-Funded Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the plan only contact you at work or by mail to a specific address. To request confidential communications, you must submit your request in writing to the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer. The plan will accommodate all reasonable requests and will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this notice. You may ask the City of De Pere to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer.

Other Uses of Medical Information. Other uses and disclosures of PHI not covered by this notice will be made only with your written permission. This includes most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and uses and disclosures of PHI that constitute a sale of PHI. If you provide the City of De Pere permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the plan will no longer use or disclose your PHI for the reasons stated in your written authorization. Please understand that the plan cannot take back any disclosures already made with your permission.

Breach. You have the right to be notified of the discovery of a breach of unsecured PHI.

Genetic Information is Protected Health Information. In accordance with the Genetic Information Nondiscrimination Act (GINA), a Self-Funded Plan will not use or disclose genetic information for underwriting purposes, which includes eligibility determinations, premium computations, applications of any pre-existing condition exclusions and any other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

CHANGES TO THIS NOTICE

The Self-Funded Plan reserves the right to change this notice and to make the revised or changed notice effective for PHI your plan already maintains on you as well as any information the plan receives or creates in the future. A copy of the current notice will be posted on the City of De Pere internal Intranet system. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, a copy of the notice that is currently in effect will be given to new health plan members and thereafter available upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with your Self-Funded Plan or with the Secretary of the Department of Health and Human Services. To file a complaint on your Self-Funded Plan, contact the City of De Pere Human Resources Department at 335 S. Broadway Street, De Pere, WI 54115; Attention: HIPAA Privacy Officer. Email will not be accepted; all complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

QUESTIONS

If you have questions or for further information regarding this privacy notice, contact the City of De Pere Employee Benefits Plan HIPAA Privacy Officer at 920-339-4045

Medicare Part D
Important Notice from the City of De Pere About Your Prescription Drug Coverage and Medicare

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

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

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

2. The City of De Pere has determined that the prescription drug coverage offered through the City of De Pere's Employee Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current City of De Pere coverage will not be affected. The UMR medical plan design is available to eligible individuals when you become eligible for Medicare Part D. You or your dependents can retain your existing coverage and choose not to enroll in a Part D plan or can enroll in a Part D plan as a supplement to, or instead of, the City of De Pere's medical plan. You and/or your spouse (if applicable) will still be eligible to receive all of your current health coverage if you or your dependents enroll in a Medicare prescription drug plan. Your current coverage pays for other health expenses in addition to prescription drugs. If you do decide to join a Medicare drug plan and drop your current City of De Pere coverage, be aware that you (and your spouse, if applicable) will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the City of De Pere and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

You will get this notice each year that you are covered under the City's retiree insurance plan. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of De Pere changes. You 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 and 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 1-800-633-4227. 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).

Your current prescription drug coverage benefit with the City of De Pere is as follows:

Level 1	$10.00 per each 30-day maximum supply
Level 2	$20.00 per each 30-day maximum supply
Level 3	$40.00 per each 30-day maximum supply
Level 4	20% Copay to $350 max per script

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/penalty.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Please contact the Plan Sponsor for further information.

Plan Sponsor
City of De Pere
Human Resources Department
Shannon Metzler, Human Resources Director
335 S. Broadway Street
De Pere, WI 54115
Telephone (920) 339-4045

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the City's Human Resources Director, Shannon Metzler at 920-339-4045 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

This brochure summarizes the health care and income protection benefits that are available to The City of De Pere's employees and their eligible dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department.

Information provided in this brochure is not a guarantee of benefits.