

2026 BENEFITS GUIDE





BENEFITS OVERVIEW

City of Port Washington is committed to offer a comprehensive benefits package to eligible, full-time employees who work an average of 30 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (Medical, Dental and Vision), the City of Port Washington provides other benefits at no cost to you (Life, Short-Term Disability, Long-Term Disability and EAP) and there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

TABLE OF CONTENTS

Benefits Overview	2
Medical Benefits	3
How Your Plans Work	5
Dental Benefits	12
Vision Benefits	13
Flexible Spending Account	14
Health Reimbursement Account	15
Life Insurance	16
Short-Term Disability	17
Long-Term Disability	17
Accident	18
Hospital Indemnity	18
Critical Illness	19
Employee Contributions	20
Retirement System Pension Plan	21
457(B) Deferred Compensation	21
Employee Assistance Program (EAP)	21
Contact Information	22
Legal Notices	23

BENEFITS OFFERED

- Medical
- Dental
- Vision
- Health Reimbursement Account (HRA)
- Flexible Spending Account (FSA)
- Life Insurance
- Voluntary Life Insurance
- Short Term Disability
- Long Term Disability
- Voluntary Accident
- Voluntary Critical Illness
- Voluntary Hospital Indemnity
- Retirement System Pension Plan
- 457(B) Deferred Compensation
- Employee Assistance Program (EAP)

ELIGIBILITY

You and your dependents are eligible for City of Port Washington benefits on the first of the month following date of hire.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact Human Resources within 30 days.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 29-30 for more details.



MEDICAL BENEFITS

Administered by UnitedHealthcare

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

UNITEDHEALTH CARE—NEXUSACO EBCE		
	In-Network	Out-of-Network
Deductible 1/1/26 to 12/31/26	\$3,500 single / \$7,000 family	\$6,000 single / \$12,000 family
Out-of-Pocket Maximum	\$7,000 single / \$14,000 family	\$12,000 single / \$24,000 family
Coinsurance	Tier 1: 20% Tier 2: 40%	50%
OFFICE SERVICES		
Primary Care Office Visit PCP REQUIRED	Tier 1: 20% after deductible Tier 2: 40% after deductible	50% after deductible
Specialist Office Visit	Tier 1: 20% after deductible Tier 2: 40% after deductible	50% after deductible
Preventive Care Services (screening, immunization)	No copay / No deductible	50% after deductible
Urgent Care Center Services	20% after deductible	50% after deductible
Virtual Care Services	Tier 1: 20% after deductible Tier 2: 40% after deductible	50% after deductible
Lab, X-Ray and Diagnostic (X-Ray, blood work)	20% after deductible	50% after deductible
Major Diagnostic and Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible
PRESCRIPTION DRUGS		
	Prescription Drug copays are applied after plan deductible is met.	
Retail—Generic Drug (34-day supply)	\$10	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or co-payment amount.
Retail—Formulary Drug (34-day supply)	\$35	
Retail—Nonformulary Drug (34-day supply)	\$70	
Mail Order—Generic Drug (90-day supply)	\$25	
Mail Order—Formulary Drug (90-day supply)	\$87.50	
Mail Order—Nonformulary Drug (90-day supply)	\$175	

This is just a summary of coverages. Refer to the SBC for additional details.

MEDICAL BENEFITS

Administered by UnitedHealthcare

UNITEDHEALTH CARE—NEXUSACO EBCE		
	In-Network	Out-of-Network
HOSPITAL SERVICES		
Emergency Room Care	20% after deductible	20% after deductible
Inpatient Care	Tier 1: 20% after deductible Tier 2: \$500 per occurrence and deductible, then 40%	\$500 per occurrence and deductible, then 50%
Outpatient Surgery	Tier 1: 20% after deductible Tier 2: \$250 per occurrence and deductible, then 40%	\$250 per occurrence and deductible, then 50%
Ambulance Service	20% after deductible	50% after deductible
MENTAL HEALTH CARE & SUBSTANCE RELATED AND ADDICTIVE DISORDER SERVICES		
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
OTHER SERVICES		
Physical, Speech, Occupational and Pulmonary Rehabilitation Services 20 visits	20% after deductible	50% after deductible
Skilled Nursing Care 30 days per calendar year	40% after deductible	50% after deductible



Health Plans | NexusACO | Wisconsin



NexusACO®

**United
Healthcare**

City of Port Washington

Quality care close to home

Wherever you live or work in the Milwaukee area, there's likely easy access to quality care from a NexusACO Tier 1 facility or physician.

NexusACO providers include:

- Advocate Aurora Health
- Children's Wisconsin
- Froedtert and Medical College of Wisconsin



Understand your costs when getting care

Copayment (or copay)

You'll usually pay a fixed amount of money for each covered doctor visit or prescription. You may pay a lower copay when you use Tier 1 providers from a list of Tier 1 facilities and physicians.



Deductible*

This is the amount you will need to pay for covered services before your plan begins to pay.



Coinsurance*

After you've paid your deductible, you only pay a percentage of the cost for each covered service. You may pay a lower percentage when you use Tier 1 providers.

Out-of-pocket limit

You'll never pay more than your out-of-pocket limit during the plan year for covered services. The out-of-pocket limit includes all of your copayment, deductible and coinsurance payments.

Choose Tier 1 providers to help save on your care. For all of the coverage details, see your official health plan documents.

Look for Tier 1 care first

TIER 1 Look for the Tier 1 symbol when doing a network search at myuhc.com.



Where you go for care can make a difference. Tier 1 providers are doctors, hospitals and other health care facilities that may offer you the greatest value for your health care benefits.*

- \$** Tier 1 (lowest-cost option when a Tier 1 provider is seen inside the ACO service area; outside the ACO service area, see a UnitedHealth Premium® provider)
- \$\$** Network (access to all other network providers)
- \$\$\$** Out-of-network (highest-cost option)

* Based solely on cost-sharing

Understand your pharmacy benefit

Your covered medications

Optum Rx® is your UnitedHealthcare plan's pharmacy care services manager. Optum Rx is committed to providing you with easier and lower-cost ways to get the medication you need.

The UnitedHealthcare Prescription Drug List (PDL) is the list of medications that are covered by the plan. The PDL is organized by cost levels, known as tiers. Choosing medications in Tier 1 may help save you money, similar to choosing a Tier 1 PCP.



Fill your prescriptions 2 ways

1. Choose from thousands of network retail pharmacies
2. Take advantage of the convenience of Optum Rx home delivery

Save on your medications

- **Use home delivery.** Up to a 3-month supply of your medications will ship free to your home, often at a lower cost than retail. You also get 24/7 phone support, medication refill reminders and more.
- **Use network pharmacies.** Pharmacies in our network have agreed to charge lower prices. Our network includes thousands of pharmacies across the country.
- **Use Tier 1 medications, such as generics.** Use the PDL to help you or ask your doctor if you have a medication that is placed in a higher tier (Tier 3, for example). Check to see if a Tier 1 option is available. The higher-cost brand medications are usually placed in higher tiers.

Manage your pharmacy benefits on the go

Use myuhc.com and the UnitedHealthcare app to:

- Enroll in home delivery
- Find network pharmacies
- Refill prescriptions and set up refill reminders
- Estimate and compare medication costs
- Search your plan's PDL



The UnitedHealthcare app can also help determine how a medication is covered and whether or not there are other options to help save you money.

Need help?



Visit myuhc.com®

Sign up for **myuhc.com** and get a personalized website that gives you access to your health plan details.



Get on-the-go access

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download it for free today to access your ID card, find nearby care and more.



Call toll-free

If you can't find answers or need assistance with questions, call the toll-free member phone number on your health plan ID card.

**United
Healthcare**

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued.

Tier 1 providers may be subject to change, visit myuhc.com® for the most current information or call the number on your health plan ID card.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with them for advice on selecting other physicians. You should also discuss designations with a physician before choosing them. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through UnitedHealthcare of Wisconsin, Inc.

B2B E1221928902.2 7/23 © 2023 UnitedHealthCare Services, Inc. All Rights Reserved. 23-2515100



Important things to know about selecting your PCP

A primary care provider (PCP) is your health guide—someone who can help coordinate your care and supports you in achieving your best health.

Your PCP:

- Must be a general practice, family practice, pediatrician or internal medicine provider*
- Must be an individual provider, not a medical practice**
- Must be accepting new patients (if you are not a current patient)
- Must be located in a town or city near where you (the subscriber) live or work
- Can be selected for the entire family or each covered member can select their own



A PCP is the doctor who knows you best—who understands your health history and health goals. They're who you turn to first—for everything from routine care to prescriptions and more.

And, since most PCPs offer virtual visits for primary care, you can choose to see them in person or from home.

So, whether or not your plan requires you to have a PCP, it's a good idea to choose one.

See reverse side for instructions on how to select a PCP.

*Some states allow you to choose a specialist, like an OB/GYN, as your PCP. Contact your employer for more information.

**Some health plans may allow you to choose a medical group rather than a doctor as your PCP.

continued

Follow these steps to choose your PCP

- 1 • Go to myuhc.com® (you don't need to sign in)
• Then select **Find a Provider** > **Medical Directory** then, **Employer and Individual Plans**.

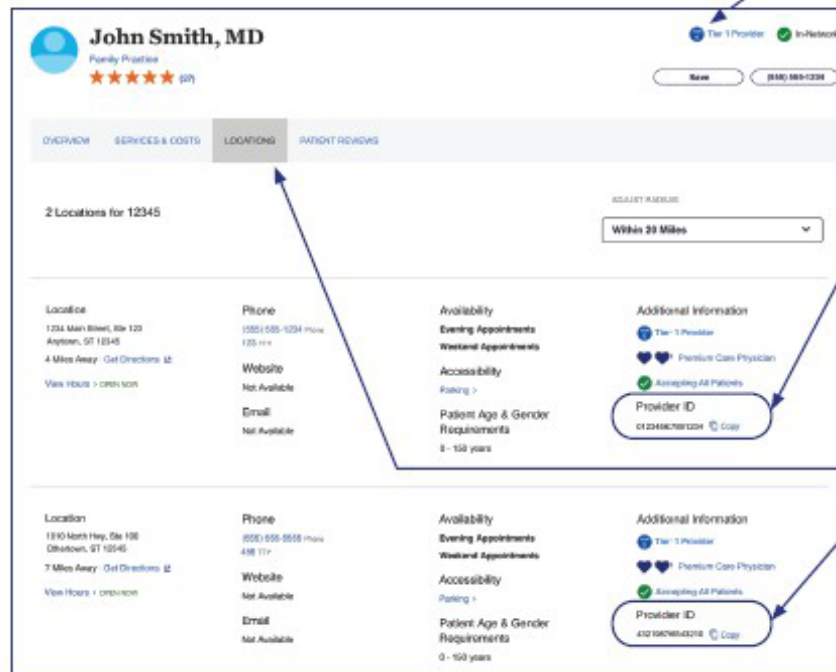
Not sure which plan name to look for? Check your open enrollment materials or ask your employer.

- 2 If prompted, select the year in which you will be receiving care (choose the following year if you are making open enrollment selections)—confirm the ZIP code for your search, choose **People**, then **Primary Care**, then select from any of the categories listed.

TIER 1

Pay less by using Tier 1 providers

Some UnitedHealthcare plans are designed so you pay less when you see Tier 1 doctors and specialists.



- 3 Scroll through the search results, and once you have made your selection, click on the provider's name to **locate the Provider ID in the lower right corner of the page**. Select **Copy** or write it down—you'll need it when you enroll.

- 4 If your selected PCP is associated with multiple locations, you can find the correct Provider ID by selecting **Locations** and then copying the appropriate Provider ID.

And there you have it—choosing your PCP is the first step in the process to help manage your health. Be sure to schedule your first visit with your PCP. It can be a great way for your doctor to get to know you—and vice versa.

Questions?

For enrollment support please call 1-866-873-3903 or visit www.myuhc.com

**United
Healthcare**

This Guide is intended for individuals selecting a new plan (or) in open enrollment. Active members should log in to myuhc.com for assistance.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Tier 1 providers may be subject to change, visit myuhc.com® for the most current information or call the number on your health plan ID card.

UnitedHealthcare Level Funded: Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Stop Loss only: Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company of New York (in NY) and UnitedHealthcare Insurance Company (in all other states and DC).

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

B2C_EI20273065.2 3/23 © 2023 United HealthCare Services, Inc. All Rights Reserved. 23-206388D-A



DENTAL BENEFITS

Administered by Delta Dental

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the City of Port Washington dental benefit plan.

SERVICES	IN-NETWORK AND OUT-OF-NETWORK PPO
Calendar Year Deductible	\$0 per person; \$0 family limit
Calendar Year Benefit Maximum	\$1,500
Preventive Dental Services (cleanings, exams, x-rays)	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	100%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%
Orthodontia Services (Dependent children up to age 26)	50% to \$1,500 lifetime maximum

Find a Dental Provider at:
deltadentalwi.com

For general questions go to:
deltadentalwi.com

or call
 800.236.3712





VISION BENEFITS

Administered by Delta Dental

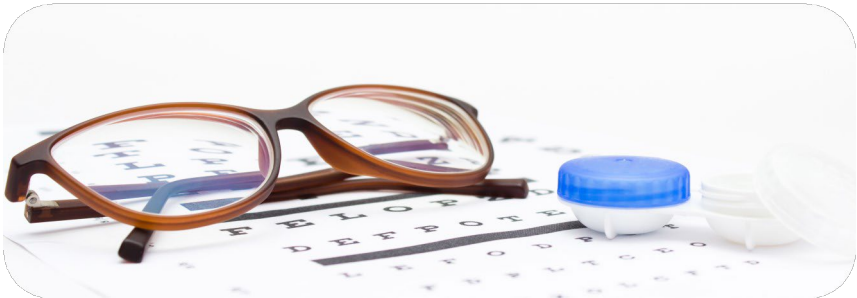
Regular eye examinations can determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone. Insured individuals are not required to see a provider in-network; however, the plan pays higher coverage levels for in-network services.

SERVICE	IN-NETWORK (ANY INSIGHT PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
Eye Exam — once every 12 months	\$10 copay	Reimburse up to \$35
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	\$10 copay	Reimburse up to \$25
Lined Bifocal Lenses	\$10 copay	Reimburse up to \$40
Lined Trifocal Lenses	\$10 copay	Reimburse up to \$55
Frames — once every 24 months	\$150 allowance plus 20% off	Reimburse up to \$75

CONTACT LENSES —ONCE EVERY 12 MONTHS IF YOU ELECT CONTACTS INSTEAD OF LENSES/FRAMES

Allowance	Conventional: \$150 allowance plus 15% off; Disposal: \$150 allowance	80% of the selected allowance amount for contacts
Medically Necessary	Covered in full	Reimburse up to \$200
Separate Fitting Allowance	Standard: \$40 allowance; Premium: 10% off retail price	None

Find a Vision Provider at:
deltavisionwi.com
 For general questions go to:
deltavisionwi.com
 or call
 844.848.7090





SPENDING ACCOUNTS

FLEXIBLE SPENDING ACCOUNT

Administered by Associated Bank

You can save money on your healthcare and/or dependent daycare expenses with a Flexible Spending Account (FSA). The FSA allows you to set aside funds each pay period on a pre-tax basis and use them tax-free for qualified expenses. Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income. FSA contributions are deducted biweekly (26 paycheck per year).

Feature	Healthcare FSA	Dependent Care FSA
Maximum contribution per year	\$3,400	\$7,500
Can be used for eligible...	Medical, dental and vision expenses for you and your dependents	Daycare expenses for eligible dependents





SPENDING ACCOUNTS

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Administered by Associated Bank

The City of Port Washington is continuing a Section 105 Health Reimbursement Arrangement (HRA) to help provide better health care coverage to employees and their families. HRAs are implemented by many employers to help manage increasing health care costs and to provide employees with an incentive to be better consumers of health care. Qualifying expense are medical, dental, vision and OTC expenses.

	City's Annual HRA Contribution	Reimbursement Levels
Employee	\$1,750	50% of the first \$3,500 of eligible expenses, up to a maximum of \$1,750
EE + Spouse EE + Child(ren) Family	\$3,500	50% of the first \$7,000 of eligible expenses, up to a maximum of \$3,500.

Please note: any excess expenses above and beyond these limits are the responsibility of the employee.





LIFE INSURANCE BENEFITS

LIFE INSURANCE

Administered by Wisconsin Department of Employee Trust Funds

The City of Port Washington provides all full-time employees with life insurance. The benefit is equal to the employee’s base annual salary rounded to the next highest \$1,000 increment. Employees are enrolled in this coverage automatically, and it cannot be waived. The City pays the full annual premium for this coverage.

Voluntary Supplemental and Additional Life Insurance

Eligible employees may purchase additional amounts of life insurance through the Guardian. Additional purchase options include a Supplemental Plan at 1x the employee’s base earnings and the Additional Plan at 3x the employee's base earnings. Premium rates vary based on age. Premiums are deducted from the first paycheck per month.

AGE	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate	\$0.05	\$0.06	\$0.07	\$0.08	\$0.12	\$0.22	\$0.39	\$0.49	\$0.57	\$1.00+
Monthly rate per \$1,000										

Voluntary Spouse/Dependent Life Insurance

Eligible employees may purchase life insurance for their spouse and dependents through the Wisconsin Department of Employee Trust Funds. The Spouse + Dependent Plan may be purchased in 1 or 2 units of coverage. Premium is deducted from the first paycheck per month.

Monthly Rates	1 Unit	2 Units
Spouse + Dependent	\$1.60	\$3.20





DISABILITY INSURANCE

DISABILITY INSURANCE

Administered by Guardian

This benefit replaces a portion of your income if you become disabled and are unable to work. Employees are enrolled in this coverage automatically, and it cannot be waived. The City pays the full annual premium for this coverage.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-Term Disability	You receive 60% of your income up to \$1,000 per week. Benefits begin after 7 calendar days of absence from work for illness and 0 calendar days for injury and continue for up to 26 weeks.	Company
Long-Term Disability	You receive 60% of your income up to \$5,000 per month. Benefits begin after 180 calendar days end and continue until you reach the Social Security Normal Retirement Age (SSNRA).	Company





ACCIDENT and HOSPITAL INDEMNITY INSURANCE

ACCIDENT INSURANCE

Administered by Guardian

A voluntary accident plan through Guardian is available to eligible employees and their spouse/dependent children. For covered accidental injuries, fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more. Premiums are deducted from the first paycheck per month.

This plan includes a \$50 per calendar year Health Screening Benefit.

Coverage Level	MONTHLY
Employee Only	\$9.67
Employee + Spouse	\$16.20
Employee + Children	\$17.09
Family	\$23.62



HOSPITAL INDEMNITY INSURANCE

Administered by Guardian

A voluntary hospital indemnity plan through Guardian is available to eligible employees and their spouse and dependent children. Hospital indemnity helps covered employees and their families cope with the financial impacts of a hospitalization. Fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. You can receive benefits when you are admitted to the hospital for a covered accident, illness or childbirth. Premiums are deducted from the first paycheck per month.

This plan includes a \$50 per calendar year Health Screening Benefit.

Coverage Level	MONTHLY
Employee Only	\$18.70
Employee + Spouse	\$42.45
Employee + Children	\$33.22
Family	\$56.98





CRITICAL ILLNESS INSURANCE

CRITICAL ILLNESS INSURANCE

Administered by Guardian

A voluntary critical illness plan through Guardian is available to eligible employees and their spouse and dependent children. The plan provides a single cash benefit to you if you're diagnosed or treated for a covered critical illness event.

Your cost depends on how much coverage you select, your age as of the effective date. You will be offered \$10K to \$30K or \$30K guaranteed issue coverage. Your Spouse/Domestic Partner will be offered \$10K to \$30K or \$30K guaranteed issue coverage and your child(ren) will also be offered 50% of your chosen benefit amount. Premiums are deducted from the first paycheck per month.



This plan includes a \$50 per calendar year Health Screening Benefit.

Monthly Premium for \$10,000 of Coverage		
Attained Age	Employee Only	Employee + Spouse
<30	\$5.80	\$5.80
30-39	\$9.60	\$9.60
40-49	\$18.70	\$18.70
50-59	\$37.20	\$37.20
60-69	\$63.60	\$63.60
70+	\$108.00	\$108.00

Monthly Premium for \$20,000 of Coverage		
Attained Age	Employee Only	Employee + Spouse
<30	\$11.60	\$11.60
30-39	\$19.20	\$19.20
40-49	\$37.40	\$37.40
50-59	\$74.40	\$74.40
60-69	\$127.20	\$127.20
70+	\$216.00	\$216.00

Monthly Premium for \$30,000 of Coverage		
Attained Age	Employee Only	Employee + Spouse
<30	\$17.40	\$17.40
30-39	\$28.80	\$28.80
40-49	\$56.10	\$56.10
50-59	\$111.60	\$111.60
60-69	\$190.80	\$190.80
70+	\$324.00	\$324.00

Note: Child coverage included at 50% of employee benefit.



EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR BENEFITS

The City contributes eighty-five (85) percent of the monthly medical insurance premium. The additional fifteen (15) percent is the responsibility of the employee. Premiums are deducted from the first two paychecks per month.

BENEFIT PLAN	MONTHLY	PER PAYCHECK
Medical/Rx		
Employee	\$135.02	\$67.51
Employee + One	\$270.04	\$135.02
Employee + Child(ren)	\$256.54	\$128.27
Family	\$432.06	\$216.03

The City contributes seventy-five (75) percent of the monthly dental insurance premium. The additional twenty-five (25) percent is the responsibility of the employee. Dental and Vision Premiums are deducted from the first two paychecks per month.

BENEFIT PLAN	MONTHLY	PER PAYCHECK
Dental Rates		
Employee	\$10.48	\$ 5.24
Employee + One	\$23.58	\$11.79
Employee + Child(ren)	\$23.58	\$11.79
Family	\$32.75	\$16.38

BENEFIT PLAN	MONTHLY	PER PAYCHECK
Vision Rates		
Employee	\$ 6.45	\$3.23
Employee + One	\$12.90	\$6.45
Employee + Child(ren)	\$13.17	\$6.59
Family	\$19.62	\$9.81





PENSION, 457(B) AND EAP

WISCONSIN RETIREMENT SYSTEM PENSION PLAN

Administered by Wisconsin Retirement System (WRS)

The City of Port Washington participates in the WRS. The WRS was created to protect public employees and their beneficiaries against the financial hardships of old age and disability and to attract and retain a qualified public workforce. WRS covers all employees who work at least 1200 hours in the calendar year.

The WRS offers a retirement benefit based on a defined contribution plan or a defined benefit plan. A defined contribution plan means there is a set amount of money (that may change each year) paid into a member's retirement account. Half of this amount is deducted from the employee's paycheck and half is paid (matched) by the employer. A defined benefit plan means that the amount paid to you in retirement is based on a formula that is fixed, and therefore "defined." For 2026, general employee contributions will equal 6.95% with a matching 6.95% paid by the City. Protective employee contributions will equal 6.95% with an additional 14.95% paid by the City.

457(B) DEFERRED COMPENSATION PLAN

The City of Port Washington offers full-time employees the opportunity to participate in a 457(b) Deferred Compensation Plan. Employees may choose to contribute on a flat dollar amount or percentage basis. Federal contribution limits cap-out at \$24,500 for 2026. The City partners with multiple vendors to administer the plan including Wisconsin Department of Employee Trust Funds, ICMA's Mission Square Retirement, and North Shore Bank.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by Guardian

The City offers all employees access to the Employee Assistance Program (EAP). EAP services include guidance from professional experienced counselors that offer free and confidential support 24/7/365 for employees struggling with personal or work-related concerns.

Help with:

- Balancing work and life
- Stress and anxiety
- Finding child or elder care
- Loss of a loved one
- Family, marital and relationship challenges
- Legal issues
- Financial issues.





CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	UnitedHealthcare	866.673.6293	myuhc.com
Dental	Delta Dental	800.236.3712	www.deltadentalwi.com
Vision	Delta Dental	844.848.7090	www.deltavisionwi.com
Flexible Spending Account	Associated Bank	800.270.7719	associatedbank.com
Short Term Disability	Guardian	800.268-2525	CRU@Glic.com
Long Term Disability	Guardian	800.538.4583	CRU@Glic.com
Accident	Guardian	800.541.7846	guardianlife.com
Hospital Indemnity	Guardian	800.541.7846	guardianlife.com
Critical Illness	Guardian	800.541.7846	guardianlife.com
Employee Assistance Program (EAP)	Guardian / ComPsych	855.239.0743	guidanceresources.com
Human Resource Manager	Robin Pena	262.284.5585	rpena@portwashingtonwi.gov





LEGAL NOTICES

PATIENT PROTECTIONS DISCLOSURE

The City of Port Washington Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, UnitedHealthcare designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the UnitedHealthcare at 866.673.6293 or myuhc.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the UnitedHealthcare at 866.673.6293 or myuhc.com.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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 the plan. Therefore, the following deductibles and coinsurance apply:

Choice Plus HDHP (Individual: 10% coinsurance and \$3,500 deductible; Family: 10% coinsurance and \$7,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 262.284.5585 or rpena@portwashingtonwi.gov.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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



LEGAL NOTICES

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, 2025. Contact your State for more information on eligibility –

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



LEGAL NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
<p>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</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfir/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>



LEGAL NOTICES

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	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	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924



LEGAL NOTICES

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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)



LEGAL NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

City of Port Washington is committed to the privacy of your health information. The administrators of the City of Port Washington Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Robin Pena - Human Resource Manager at 262.284.5585 or rpena@portwashingtonwi.gov.

HIPAA SPECIAL ENROLLMENT RIGHTS

City of Port Washington Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Port Washington Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage 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 (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. 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.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance 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 to obtain more information about the plan's special enrollment provisions, contact Robin Pena - Human Resource Manager at 262.284.5585 or rpena@portwashingtonwi.gov.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.



LEGAL NOTICES

NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Port Washington 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 City of Port Washington 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. City of Port Washington has determined that the prescription drug coverage offered by the 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 15th to December 7th.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Port Washington coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current City of Port Washington coverage, be aware that you and your dependents may 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 City of Port Washington and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Port Washington changes. You also may request a copy of this notice at any time.



LEGAL NOTICES

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 01, 2026
Name of Entity/Sender:	City of Port Washington
Contact—Position/Office:	Robin Pena - Human Resource Manager
Office Address:	100 W Grand Ave, PO BOX 307
	Port Washington, Wisconsin 53074-2217
	United States
Phone Number:	262.284.5585



LEGAL NOTICES

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

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



LEGAL NOTICES

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Robin Pena.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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



LEGAL NOTICES

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

City of Port Washington
 Robin Pena - Human Resource Manager
 100 W Grand Ave, PO BOX 307
 Port Washington, Wisconsin 53074-2217
 United States
 262.284.5585

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>



LEGAL NOTICES

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

²An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.



LEGAL NOTICES

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Robin Pena.

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



This benefit summary prepared by



Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.