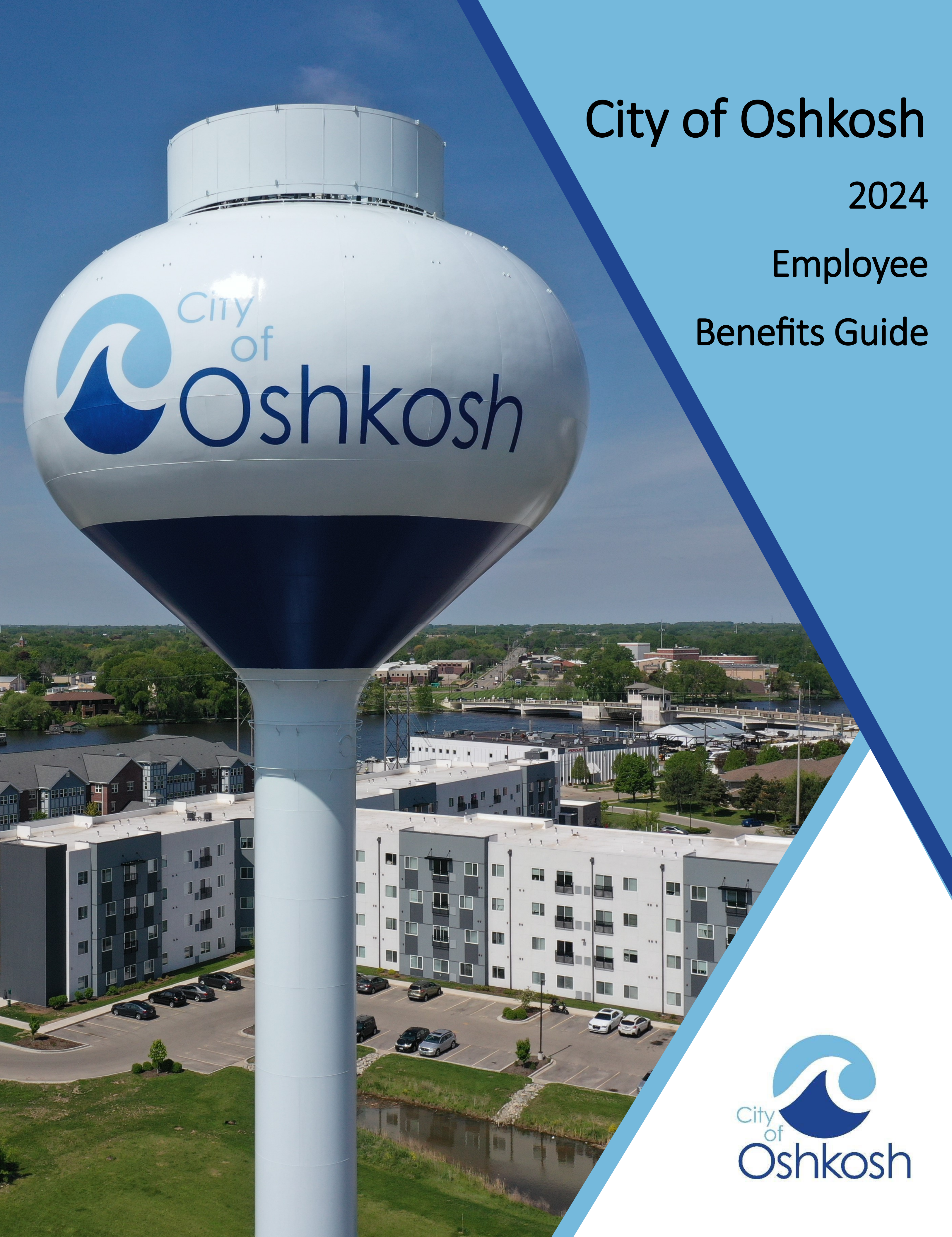

City of Oshkosh

2024

Employee

Benefits Guide

Welcome

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Welcome to the City of Oshkosh employee benefits program. This guidebook is meant to help you get to know your benefits and choices for the 2024 plan year. Be sure to learn about your options so you can make informed choices for yourself and your eligible dependents.

At City of Oshkosh we recognize our ultimate success depends on our talented and dedicated workforce. We appreciate the contribution each employee makes to our accomplishments. Our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access, and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

We encourage you to keep this guidebook, along with your other benefits information, as you may want to refer to it periodically. This guidebook is also available in the Benefits section of the intranet at https://www.ci.oshkosh.wi.us/intranet/Benefits.aspx.

If you have any questions regarding the City of Oshkosh benefits, please contact Kim Kautza at 920-236-5138 or kkautza@ci.oshkosh.wi.us.

Employee Self Service (ESS)

The Employee Self Service (ESS) portal is a convenient, secure website that you will use to enroll or waive medical, dental, vision and/or flexible spending benefits both upon hire and during annual open enrollment.

To access ESS from work or home, type in your internet browser https://selfservice.ci.oshkosh.wi.us/ess/ . Click "Log In" in the top right area of the header. You may also access ESS via your smartphone by installing the "ESS Mobile" app.

Your username is the first initial of your first name, your last name, and the last 4 digits of your social security number (Ex: jsmith1234).

Please use the password that you previously established for ESS. If this is the first time you've ever logged into ESS (new hires) or if you request HR to reset your ESS password, your initial password will be password (all lower case) and you will be prompted to change your password after the 1st login. Remember your password so you can access ESS at any time.

Once logged into ESS, click on "Benefits" on the right side of the screen. Then click on "Select" for each benefit to elect or waive each coverage listed, then "Continue". Be sure to hit "Submit" once all of your selections have been made. You will receive a confirmation email.

In addition to making your benefits selections, ESS is a great resource to view your paychecks, paid time off balances, W2s as well as to report any new qualified life events, such as marriage, birth or loss of other coverage, etc. You may use ESS to make changes to your W4s and personal information, such as home address, phone number, emergency contacts and tax withholdings. Changes made in ESS will automatically update in our payroll system.

Should you need your password reset or if you have any issues/questions regarding ESS, please contact Human Resources at 920-236-5110 or via email at cityofoshkoshHR@ci.oshkosh.wi.us

Contact Information

Have Questions? Need Help?

Listed below are the customer service contacts for all our benefit offerings. If you have a question or need assistance, please contact the applicable carrier using the information provided below.

If additional support is needed OR if you are looking to complete any changes to your benefits that are not related to your initial or annual enrollment, you may contact Kim Kautza in Human Resources at 920-236-5138 or **kkautza@ci.oshkosh.wi.us**.

Carrier Customer Service

Benefit	Carrier	Phone Number	Website
Medical	UMR	800-826-9781	www.umr.com
Prescription Drug	CVS Caremark	866-818-6911	www.caremark.com
Three Waves Clinic	Premise	920-267-5332	www.mypremisehealth.com
Dental	Delta Dental of WI	800-236-3712	www.deltadentalwi.com
Vision	Delta Vision/EyeMed	844-848-7090	www.deltadentalwi.com or www.eyemed.com (Access network)
Employee Assistance Program (EAP)	Empathia LifeMatters	800-634-6433 First Responder Support Line – 877-307-2813	www.mylifematters.com
Flexible Spending Accounts	TASC (Total Administrative Services Corporation)	800-422-4661	www.tasconline.com/ubaaccess
Group Life	WI Department of Employee Trust Funds (ETF)	877-533-5020	https://etf.wi.gov/benefits/benefits-provided-etf/life-insurance
Income Continuance Insurance	WI Department of Employee Trust Funds (ETF)	877-533-5020	https://etf.wi.gov/benefits/benefits-provided-etf/income-continuation-insurance
Retirement	WI Department of Employee Trust Funds (ETF) MissionSquare (previously ICMA-RC)	877-533-5020 800-669-7400	https://etf.wi.gov/retirement www.missionsq.org

This brochure summarizes the benefit plans that are available to City of Oshkosh eligible employees and their 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 Human Resources. Information provided in this brochure is not a guarantee of benefits.

Eligibility

Who is Eligible:

You may enroll in the City of Oshkosh Employee Benefits Program if you are a benefits eligible employee working at least 1,200 or more hours per year.

When Coverage Begins:

Benefits elected during open enrollment are effective January 1, 2024.

Newly hired employees and dependents will be effective in City of Oshkosh's benefits programs on the 1st day of the month following 30 days of employment. However, if your first day of work is between the 1st day and the 5th day of the month, you will be eligible for benefits the 1st day of the following month.

All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a qualifying life event.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren, and children obtained through court-appointed legal guardianship.

Changes in Benefit Elections

Making changes to your coverage during the plan year

To protect the tax advantages of your benefits, your employer is required to follow certain IRS rules. These rules affect when you may change your benefits and what changes you may make.

You may change your benefit elections mid-year for the following events:

- The addition of dependents due to the birth or adoption of a child
- Your marriage
- The death of one of your dependents
- A change in the employment status of your spouse or dependent, including the termination or commencement of employment, loss of work due to a strike or lockout
- Your dependent loses or gains benefit eligibility of an employer's benefit plan
- Your spouse or dependent's employer's open enrollment
- Your divorce, legal separation, annulment

Notification of a mid-year event must be made within 30 days of the event.

Remember, due to Internal Revenue Service (IRS) regulations, changes can only be made to your enrollment elections during open enrollment or if you experience a qualifying event that allows you to make a change mid-year.

IMPORTANT
REMINDER

TERMS YOU NEED TO KNOW

Allowable Charges:
Charges for services rendered or supplies furnished by a health provider that would qualify as covered expenses and for which the health insurer pays in whole or in part, subject to any deductible, coinsurance, or copayments.

Coinsurance:
A percentage of medical plan costs that you pay after your deductible is met.

Copayments (Copay):
A predetermined, flat fee an individual pays for healthcare services, in addition to what insurance covers. A copay is the amount that must be paid to the provider each time certain services are received. Copays do not apply toward satisfaction of deductibles, but they do track toward out-of-pocket maximums.

Deductible:
A fixed dollar amount that you pay before the plan will begin paying benefits.

Drug Formulary:
A list of prescription drugs approved for use and/or coverage under a particular health insurance policy. The development of prescription formularies are based on evaluations of efficacy, safety, and cost-effectiveness of drugs.

Family Deductible:
A deductible that is satisfied by the combined expenses of all covered family members. For example, a program with a $1000 deductible may limit its application to a maximum of two deductibles ($2,000) for the family, regardless of the number of family members. An aggregate family deductible may be met by two or more family members.

In-Network:
Doctors, hospitals, and other providers with whom the medial plan has an agreement to care for its members. Covered employees and dependents have lower out-of-pocket costs when using in-network providers.

Out-of-Network:
Care received from a doctor, hospital, or provider with whom the plan does not have an agreement. Covered employees and dependents pay more to use out-of-network providers, including anything over usual and customary.

Out-of-Pocket Maximum:
The total amount of deductible and coinsurance the covered person incurs. This accumulates on an individual and family level. The family out-of-pocket maximum is an aggregate. The medical plan has separate medical and prescription drug out-of-pocket maximums.

Primary Care Physician (PCP):
PCPs are Family Practitioners, Internists, Pediatricians, OB/GYNs, Nurse Practitioners, or Physician Assistants.

Preferred Provider Organization (PPO):
A group of hospitals and physicians that contract on a fee-for-service basis with employers, insurance companies, or other third party administrators to provide comprehensive medical service. Providers exchange discounted services for increased volume and prompt payment. Participants' out-of-pocket costs are usually lower than with a fee-for-service plan.

Employees enrolled in the City's health plan have access to the **UnitedHealthcare Choice Plus PPO Network** through UMR.

You can search for participating providers on the UMR website.

Premium:
This is the amount the City withdraws from your paycheck to help cover the cost of the insurance. This does not apply to your deductible or out of pocket maximum.

Prior Authorization:
Some medical services may need to be approved before you receive the services. For more information, please review the Prior Authorization section of your plan document. Please remember, a Prior Authorization is not a guarantee of coverage.

MEDICAL COVERAGE

The City of Oshkosh offers medical coverage through UMR utilizing the UnitedHealthcare (UHC) Choice Plus PPO Network. The UHC Choice Plus PPO Network is a National network with participating providers throughout the United States. For more information or for assistance in finding a provider you may also contact UMR at 800-826-9781 or access information online at www.umr.com and select the **UnitedHealthcare Choice Plus Network**.

The chart below is a brief outline of the plan. Please refer to the UMR Summary Plan Description (SPD) for plan details.

Benefit	UMR Group #76-415159	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Coinsurance	80%	60%
Maximum Out-of-Pocket		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Physician Office Visit		
Primary and Specialty Care	80% after deductible	60% after deductible
Preventive Care		
Adult Periodic Exams	100% coverage	60% after deductible
Well-Child Care	100% coverage	60% after deductible
Diagnostic Services		
X-ray and Lab Tests	80% after deductible	60% after deductible
Complex Radiology (MRIs, CAT Scans)	80% after deductible	60% after deductible
Urgent Care	80% after deductible	80% after deductible
Emergency Room	80% after deductible	80% after deductible
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Hospital	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Mental / Behavioral Health and Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Other Services		
Physical, Occupational & Speech Therapy	80% after deductible	60% after deductible
Chiropractic Care	80% after deductible	60% after deductible
Ambulance	80% after deductible	80% after deductible
Pharmacy Maximum Out-of-Pocket		
Individual	$4,150	
Family	$8,300	

Pharmacy	In-Network		Out-of-Network
	Retail Pharmacy 30 Day Supply	Mail Order Pharmacy 90 Day Supply	Reimbursement is not guaranteed Mail Order Not Covered
Generic (Tier 1)	$15 copay	$30 copay	Contracted rate minus any applicable copayment. Employee is responsible for the cost upfront.
Preferred (Tier 2)	$40 copay	$80 copay	
Non-Preferred (Tier 3)	$70 copay	$140 copay	
Generic Specialty (Tier 4)	$150 copay	30 Day Supply Only	Not covered
Preferred Specialty (Tier 5)	$150 copay	30 Day Supply Only	Not covered
Non-Preferred Specialty (Tier 6)	$250 copay	30 Day Supply Only	Not covered

Bi-weekly Contributions (24 pay periods)				
Full-Time Employees	**With** Health Risk Assessment Participation		**Without** Health Risk Assessment Participation	
	Employee Contribution (12%)	City Contribution (88%)	Employee Contribution (15%)	City Contribution (85%)
Single	$58.71	$430.54	$73.39	$415.86
Employee & Spouse	$118.37	$868.09	$147.97	$838.49
Employee & Child(ren)	$118.37	$868.09	$147.97	$838.49
Family	$147.58	$1,082.26	$184.48	$1,045.36

Part-Time Employees	Employee Contribution (12% of Single Rate)	City Contribution (88% of Single Rate)	Employee Contribution (15% of Single Rate)	City Contribution (85% of Single Rate)
Single	$58.71	$430.54	$73.39	$415.86
Employee & Spouse	$555.91	$430.55	$570.60	$415.86
Employee & Child(ren)	$555.91	$430.55	$570.60	$415.86
Family	$799.30	$430.54	$813.98	$415.86

PPO Provider Network to receive the In-Network Benefit Level

To receive the maximum benefit available / **in-network benefits** under your medical plan, it is recommended that you receive care by a UnitedHealthcare preferred (contracted) provider by accessing the **UnitedHealthcare Choice Plus** network.

It is important to note that when searching for in-network providers you will want to look for those providers with a two blue heart stamp ♥ ♥. This stamp signifies Premium Care Physicians in your network who offer their services at a lower cost while maintaining the highest quality. While the City's medical plan benefits are not designed to steer you to these providers, you may pay less in out-of-pocket costs and have better outcomes by using a provider who meets the standards for quality and cost efficiency.

Medical Coverage – Create an online profile at umr.com

Once you have your UMR member ID card, we encourage you to register through UMR's website at **www.umr.com.** This website provides you with access to the provider network and other benefit information specific to your medical plan.

If you already have an account, simply enter your username and password in the upper-right corner. If it is your first time logging in, click on **Login/Register** in the upper right corner of the screen. On the next screen select **Member.** Make sure you have your ID card handy and follow the steps to get started.

In addition, the website includes many features such as a health cost estimator, health education library, forms, and the ability to view your claims and download Explanation of Benefits (EOBs).

The Health cost estimator allows you to research treatment options and learn about recommended care and estimated costs associated with your selected treatment option. It's easy to get started; just look for the Health cost estimator tile on your personal home page.

UMR has also gone mobile. You have Secure Mobile Web Access to look up claims, check your benefits, find providers, and view ID cards. You can use the same username and password that you use on the UMR website.

Accessing Your Prescription Drug Benefits

You may access information about your prescription drug coverage through the CVS Caremark website at Caremark.com. By registering online and creating an account, you can keep up to date on new and unique ways to save. CVS Caremark also has a mobile app that you can use to manage prescriptions, receive text refill reminders, and check drug cost and coverage.

Preferred Medication Lists

If you are not registered with CVS Caremark, you can also view preferred medication lists online using the links below:

Advanced Control Formulary

Please visit https://info.caremark.com/acdruglist to see the current quarter or next quarter's preferred drug list. Under the Know What's Covered heading, CLICK on the applicable list depending on the date you plan to purchase your medication.

- Generics will be reflected on the preferred medication list in *lower case italics*.
- Preferred brand name medications will be reflected on the preferred medication list in ALL CAPS.
- Non-preferred brand name medications will not appear on the preferred medication list. Please contact Customer Care at 866-818-6911 for more information about cost/coverage of non-preferred options or discuss with your provider if a generic or preferred brand is right for you.

Specialty Medications

Please visit https://info.caremark.com/acsdruglist to access the Advanced Control Specialty Formulary. Under the Know What's Covered heading, CLICK on the applicable list depending on the date you plan to purchase your medication.

To learn more about CVS Specialty and for additional tools and resources, visit https://CVSSpecialty.com. If you or your doctor have questions, call CVS/Specialty toll-free at 800-237-2767.

Here are some tips to help you save time and money on your medications:

1. **Be sure any retail pharmacy you use is in your network.** Network pharmacies are included in your prescription plan to help keep costs low. If you fill out-of-network, you will have to pay 100% of the cost. Find a network pharmacy before you fill at **Caremark.com.**

2. **Know which medications are covered.** Your plan's list of covered medications can help you and your doctor find the most cost-effective drug option. Find your plan's list of covered medications at **Caremark.com**.

3. **Use the *Check Drug Cost* tool available at Caremark.com**. You'll be able to do a side-by-side comparison of your medications to see where you could be saving.

4. **Ask your doctor if there is a generic option for your brand-name medication**. Proven just as safe and effective as brand-name medications, generics may be an affordable option for your treatment.

5. **Have 90-day supplies delivered by mail.** Save on medications you take regularly when you fill in 90-day supplies through our mail service pharmacy. 90-day supplies typically cost less and there is no extra cost for shipping. Visit **Caremark.com/mail service** to get started.

   In addition to obtaining a 90-day supply by mail, you have the option of obtaining a 90-day supply at any CVS Pharmacy location, including those located inside Target stores.

Employee Clinic

Three Waves Health Clinic & Wellness Center (Three Waves Clinic) is a partnership between the City of Oshkosh, Oshkosh Area School District and Winnebago County to enhance the level of healthcare provided to employees and their family members.

The Three Waves Clinic is available to City of Oshkosh employees, spouses, and dependent children age 24 months and up enrolled in the medical plan.

We want the Three Waves Clinic to be the top choice for you and your family's primary, preventive, and acute care needs. Our high-quality providers can offer you the time and attention your health deserves. They can help manage your general primary care plus most urgent care needs. Additionally, the clinic providers can provide support and care for a variety of chronic conditions. While the clinic is not a walk-in clinic, they do their best to accommodate same day or next day appointments whenever possible.

Personal Health-Care That's Different

Affordable:

- No cost to eligible members

Convenient:

- Easy scheduling: online, phone app, or telephone
- Convenient location
- Minimal wait times
- Same or next day appointments may be available
- Virtual health visits during and after hours
- Secure messaging with care team available

Quality:

- More dedicated time with the provider
- Appointments are not double booked so the provider can focus solely on you and your needs for an extended amount of time

Private & Secure:

- Operated by a third party, Premise Health
- Your personal health records are confidential and private, protected by HIPPA

Location and Contact Information
292 Ohio Street
Oshkosh, WI 54902
P: 920.267.5332
F: 920.267.5287

Virtual Care—Primary care around the clock

Virtual care through Premise Health, you now have on demand access to a team of providers who are available 24/7, so you can get the care you need, when and where you need it.

Sign in to MyPremisehealth.com
and select "Get Care Now"

Personal Health

Preventive Care
• Routine wellness exams
Acute Illness
• Allergy care
• Cold, flu, etc.
• Headaches
• Infections (bacterial, ear, eye, sinus, urinary tract, viral, etc.)
• Rashes and skin conditions
• Sore throat
Minor Injuries / Procedures
• Mole removals
• Muscle and joint pain
• Sprains and strains
Coordination with Outside Providers
Referral to Specialists
	Lab Work & Vaccinations
	• Routine vaccinations
	• Order, conduct, interpret and consult on routine diagnostic lab work, including, but not limited to:
	  • Blood sugar
	  • Cholesterol
	  • Complete blood count
	  • COVID-19 testing
	  • Flu testing
	  • Pregnancy testing
	  • Preventive labs
	  • Strep throat testing
	  • Triglycerides
	  • Thyroid
	  • Urinalysis
	• Can complete lab draw with orders from outside provider
		Physical Therapy
		Medication Management
		• Prescribe medication, after thorough assessment
		• Onsite Pre-Packaged RXs
		Chronic Condition Management
		• Anxiety / depression
		• Asthma
		• Blood pressure
		• Cholesterol
		• Diabetes
		Care Coordination
		24/7 Virtual Primary Care
		Wellness Programing
		• Onsite Wellness Coach

Dental

DELTA DENTAL

About the Dental Plan: This is a comprehensive plan for all dental services and covers preventive care at 100% in-network, with no deductible. You may use any dentist for your dental services; however, your lowest out-of-pocket cost comes from seeing a Delta Dental PPO dentist. You will also save on out-of-pocket cost by seeing a Delta Premier dentist. Always use an in-network provider to obtain the highest level of benefits.

When accessing care out-of-network, there are no provider discounts and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

Access your dental account information online at www.deltadentalwi.com or via smartphone or mobile device through Delta Dental's app. Using these tools, you can view your summary of benefits or claims, access your ID card, and find in-network dentists. For more information or for assistance in finding a provider, you may also contact Delta Dental at 800-236-3712.

The chart below is a brief outline of the plan. To learn more about the Delta Dental plan, please refer to the dental summary plan description (SPD) for complete plan details.

Benefit	Delta Dental of Wisconsin Group #91921		
	Delta Dental PPO Provider	Delta Dental Premier Provider	Non-Contracted Provider
Annual Deductible			
Individual	$50	$50	$100
Family	$150	$150	$300
Annual Benefit Maximum			
Per Individual	$1,500	$1,000	$500
Diagnostic & Preventive			
Exams, cleanings, x-rays, sealants, space maintainers, fluoride treatments, and emergency treatment to relieve pain	100%, deductible waived	100%, deductible waived	50%, deductible waived
Basic & Major Services			
Fillings	80% after deductible	80% after deductible	40% after deductible
Extractions – nonsurgical	80% after deductible	80% after deductible	25% after deductible
Extractions surgical & other oral surgery	80% after deductible	50% after deductible	25% after deductible
Endodontics & periodontics (surgical & nonsurgical)	80% after deductible	50% after deductible	25% after deductible
Crowns, inlays, onlays, dentures, bridges, & implants	50% after deductible	50% after deductible	25% after deductible
Orthodontia (Dependent Children to Age 19)			
Benefit Percentage	50%	50%	None
Individual Lifetime Maximum	$2,000	$2,000	

Bi-weekly Contributions (24 pay periods)				
Tier	Full-Time Employee Contribution (15%)	Full-Time City Contribution (85%)	**Part-Time** Employee Contribution (15% of Single Rate)	**Part-Time** City Contribution (85% of Single Rate)
Single	$2.63	$14.88	$2.63	$14.88
Employee + 1	$5.33	$30.17	$20.63	$14.87
Family	$10.04	$56.89	$52.06	$14.87

Vision

VISION COVERAGE

The vision plan is offered through Delta Vision utilizing the Eye Med Insight provider network.

About the Vision Plan: This is a comprehensive plan for all vision services. You may use any provider for your vision services; however, using an in-network provider will reduce your out-of-pocket costs.

The chart below is a brief outline of the plan. Please refer to the certificate of coverage for complete plan details.

For more information or for assistance in finding a provider, you may contact the EyeMed Customer Care Center at 844-848-7090 or access information on the Delta Dental website at www.deltadentalwi.com or www.eyemed.com (Access Network).

Delta Vision Group # 41263 EyeMed ACCESS Network		
Benefit	Network Benefit	Non-Network Reimbursement
Routine Exam (every 12 months)		
Routine Exam	Member pays $20, plan pays balance	$35
Retinal Imaging	Member pays up to $39	None
Laser Vision Correction (Lasik or PRK)	15% off retail price or 5% off promotional price	None
Frames (every 12 months)		
Frames	$150 allowance, then 20% off balance	$75
Standard Plastic Lenses (every 12 months)		
Single Vision	Member pays $20, plan pays balance	$25
Bifocal	Member pays $20, plan pays balance	$40
Trifocal	Member pays $20, plan pays balance	$55
Standard Progressive	Member pays $85, plan pays balance	$40
Lens Options		
UV Coating	Member pays $15	None
Tint (solid & gradient)	Member pays $15	None
Standard Scratch Resistance	Member pays $15	None
Standard Polycarbonate	Member pays $40	None
Standard Anti-Reflective Coating	Member pays $45	None
Other Add-Ons and Service	20% off retain price	None
Contact Lens Fitting		
Standard Contact Lens	Member pays $0	$40
Premium Contact Lens	10% discount off retail, plus $55 allowance	$40
Contact Lenses – In lieu of glasses		
Conventional	$150 allowance, then 15% off balance	$120
Disposable	$150 allowance	$120
Medically Necessary*	Paid in full	$200

Employee Contributions (Monthly)	
Single	$5.83
Employee + 1	$11.10
Family	$17.41

* Medically necessary contacts require authorization from a vision doctor when some conditions are present. Please contact the vision plan for more information.

FLEXIBLE SPENDING ACCOUNT

The Flexible Spending Account (FSA) plan with TASC - Total Administrative Services Corporation allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service. Or, you may pay for the eligible expense out of pocket, then submit your receipt to be reimbursed by the plan via a paper claim form or by logging into your account to request reimbursement at www.tasconline.com, or by using the TASC mobile app.

Important rules to keep in mind:

- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. **Re-enrollment is required each year**.

Maximum Annual Election	
Health Care FSA	$3,050
Dependent Care FSA	$5,000

For more information, you may contact TASC at 800-422-4661 or access information online at https://uba.tasconline.com/login.

EMPLOYEE ASSISTANCE PROGRAM

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices, or locating further help.

It's free... Your employer covers the cost of initial assessment, additional problem-solving sessions, and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.

It's confidential... Your EAP has been set up with Empathia, an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

Empathia's LifeMatters EAP is only a phone call away at 800-634-6433 or via website at www.mylifematters.com (password OSH1).

First Responders' LifeMatters EAP focuses on the unique needs of police, fire, EMT and ambulance personnel, and their families. First Responder EAP can be reached at 877-307-2813 or www.mylifematters.com (password OSHFRS).

Life Insurance

The City of Oshkosh provides Basic Life insurance to eligible employees through the Wisconsin Department of Employee Trust Funds (ETF). Employees are enrolled for coverage equal to 1 times your previous year's WRS earnings rounded to the next higher $1,000. Premiums are paid by the City. The benefit is effective the 1st of the month following 30 days of employment.

For more information about this benefit, go to the EFT website at https://etf.wi.gov and access the Wisconsin Public Employers Group Life Insurance Program (ET-2101) brochure or you may click on the following link: https://etf.wi.gov/publications/et2101/download?inline.

You may obtain supplemental term life and additional term life coverage by completing an application provided by the City. Applications must be submitted within 30 days of hire. If you do not enroll for available coverage within 30 days of first becoming eligible, or within 30 days of a family status change event, you may obtain coverage by providing Securian Financial with satisfactory evidence of insurability. Information about the available coverage and cost is provided on the next page. Contact Kim Kautza in Human Resources for additional information at 920-236-5138 or kkautza@ci.oshkosh.wi.us.

Life can change in an instant. Be prepared by purchasing life insurance coverage for yourself and your family through the Wisconsin Public Employers Group Term Life Insurance Program.

Your optional coverages

Coverage options	Active employees	Retirees
Basic term life	**1x** previous year's WRS earnings, rounded to the next higher $1,000 (if not already a multiple of $1,000). At age 70, coverage for employees automatically continues and reduces to 25%.* No further premiums are due from the employee to continue this coverage.	• If retired, coverage continues at 100% until age 65. • Coverage reduces to 75% at age 65, 50% at age 66, and 25%* at age 67. • Premiums are deducted from monthly annuity until age 65. Thereafter, insurance is free for the lifetime of the retiree.
Supplemental term life	**1x** previous year's WRS earnings, rounded to the next higher $1,000 (if not already a multiple of $1,000). At age 70, coverage for employees terminates.	• If retired, coverage continues at 100% until age 65 and then coverage ends.
Additional term life	**1x**, **2x** or **3x** previous year's WRS earnings, rounded to the next higher $1,000 (if not already a multiple of $1,000).	• If retired, coverage continues at 100% until age 65 and then coverage ends.

*50 percent for local employers who have opted for the higher post-retirement benefit.

Coverage type	Coverage amount	Additional information
Spouse and Dependent term life	Coverage options available: Spouse: **$10,000** Each dependent child: **$5,000** Spouse: **$20,000** Each dependent child: **$10,000**	• Coverage is for an insured employee's eligible spouse and dependent(s). • Dependent children are eligible up to age 26. Coverage may continue beyond age 26 for disabled children. • Coverage ceases when employee reaches age 70 or retires, whichever occurs first.

Monthly cost of coverage

Rates increase with age and are subject to change

Basic, Supplemental and Additional term life (Rates/$1,000/month)	
Age	Employee
Under 30	$0.05
30-34	0.06
35-39	0.07
40-44	0.08
45-49	0.12
50-54	0.22
55-59	0.39
60-64	0.49
65-69	0.57

Spouse and Dependent term life (Rates/month) One monthly premium covers all eligible insureds		
Spouse: Each dependent Child:	$10,000 $5,000	$1.60
Spouse: Each dependent Child:	$10,000 $5,000	$3.20

Rates are effective through June 30, 2024.

Additional features

Beyond paying a benefit in the event of your death, your group life insurance plan has other important features:

- **Early benefit payments if diagnosed as terminally ill** – If an insured person becomes terminally ill with a life expectancy of 12 months or less, you may request early payment of up to 100 percent of the life insurance amount.
- **No premiums if you become disabled** – If you become totally and permanently disabled from earning any income according to the terms of your certificate, life insurance premiums may be waived.
- **Accidental death and dismemberment and loss of use** – If you are killed in a covered accident or suffer a loss of a limb in a covered accident, additional payments may be made.

How much life insurance do I need?

Check out our life insurance calculator at LifeBenefits.com/insuranceneeds

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to the Wisconsin Public Employers Group Life Insurance Program. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations and terms of coverage. All elections or increases are subject to the actively at work requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Products are offered under policy form series 2832-G.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its affiliates. Minnesota Life Insurance Company is an affiliate of Securian Financial Group Inc.

INSURANCE
INVESTMENTS
RETIREMENT

lifebenefits.com

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Income Continuation Insurance

The City of Oshkosh offers the Income Continuation Insurance (ICI) benefit to eligible employees through the Wisconsin Department of Employee Trust Funds (ETF). This is a voluntary “income replacement” benefit payable if you become disabled.

The ICI program is authorized by Wisconsin Statute § 40.62 and is funded by premium contributions. ETF contracts with an external company (the plan administrator) to issue eligibility determinations and process individual claims.

ICI benefits provide **up to 75% of your average monthly 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.

Standard Coverage covers up to $64,000 of annual earnings.

- The maximum benefit is $4,000 per month.
- The premiums are paid by the employer and employee.

Supplemental Coverage is available to employees whose annual earnings exceed $64,000 (between $64,000 and $120,000 of annual earnings).

- The maximum combined benefit is $7,500 per month.
- You must have standard coverage to apply for supplemental coverage.
- You must ensure your entire earnings are above $64,000. There is no partial coverage.
- The premiums are paid entirely by the employee.*
- Each January, your employer will review your prior year’s earnings to determine if you are eligible to enroll in supplemental coverage. If your earnings drop below the $64,000 limit, the supplemental coverage will cease.

ICI provides replacement income for short-term and long-term disabilities. The benefit usually lasts until you are no longer disabled, or you reach age 65 (with some exceptions), whichever is sooner.

Before the benefit starts, you must serve an elimination period (also called a waiting period). You may select an elimination period of up to 180 days. *You must be completely off work during the elimination period*.

The City pays for a 180-day elimination (waiting) period. Shorter elimination periods are available to purchase at a cost to the employee.* You may obtain income continuation insurance coverage by completing an application provided by the City. Applications must be submitted within 30 days of hire (or within 30 days of becoming a WRS-participating employee if you were not considered a participating employee at the time you were initially hired). You apply to enroll or reduce your elimination period at any time in the future if you are medically insurable and provide evidence of insurability.

ICI benefits will not duplicate benefits available from other Wisconsin Retirement System (WRS) programs, the Social Security Administration, workers’ compensation, unemployment compensation, or certain other sources. You will be required to repay duplicate benefits back to the ICI program.

Note: Benefit durations for pregnancies - As with any disability claim, you must serve your elimination period prior to receiving an ICI benefit. 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.

For more information about this benefit, go to the ETF website at https://etf.wi.gov and access the Local Income Continuation (ET- 2129) brochure or you may click on the following link: https://etf.wi.gov/publications/et2129/download?inline=. Or you may contact Kim Kautza in Human Resources for additional information at 920-236-5138 or kkautza@ci.oshkosh.wi.us.

*The Local ICI program is currently under a premium holiday. There is no cost to the benefit for 2024.

WI Retirement System (WRS) Trust Funds

The WRS is a qualified retirement system under Section 401(a) of the Internal Revenue Code that is managed by the Department of Employee Trust Funds (ETF). The WRS is a pension plan that is intended to provide you with a lifetime retirement payment (annuity) once you are vested and have reached minimum retirement age. WRS benefits are calculated using two methods, the formula method and the money purchase method. ETF calculates your benefits using both methods and automatically pays you the higher amount.

- The employer and employee contribution rates are determined by ETF on an annual basis.
- Eligible employees are immediate participants and begin contributing with their first paycheck.
- Employee will be a participant in the Core Trust Fund (CTF), but may also elect to participate in the Variable Trust Fund (VTF). Electing VTF will give you more diversification in your retirement benefits. If electing VTF, 50% of the contributions go in the CTF and 50% in the VTF. ETF allows additional contributions to be made on an after-tax basis.

Election to Participate in the Variable Trust Fund
If you are a new WRS participant (and if you choose to participate in the Variable Trust Fund) and your election form is received by Employee Trust Funds (ETF) within 30 calendar days after your WRS coverage begin date, your Variable participation is effective on your first day of WRS-covered employment. If your form is received by ETF 31 or more calendar days after your WRS coverage begin date, your Variable participation becomes effective January 1 of the year after ETF received your election form.

When do You Become Vested?
Vesting is the minimum number of years of employment you need to qualify for a retirement benefit. WRS members must be vested (and at minimum retirement age) to be eligible for a retirement benefit that includes employer contributions and the associated interest. You may have to meet one of two vesting laws depending on when your WRS employment first began:

- 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, then 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 Joined the WRS After July 1, 2011
If you first became WRS eligible on or after July 1, 2011, you need five years of creditable service to be eligible for a retirement annuity or lump-sum retirement benefit.

- The full-time equivalent of one year of creditable service is 1,904 hours.

If you are not vested when you terminate all WRS employment, you are only eligible for a separation benefit, which includes your employee contributions, additional contributions (if applicable), and interest. You will lose your employer contributions and associated interest (approximately half your WRS account value).

WRS Resources:

WRS Core - Your Benefit Handbook: https://etf.wi.gov/publications/et2119/download?inline

WRS Variable Trust Fund: https://etf.wi.gov/publications/et4930/download?inline

WRS Additional Contributions: https://etf.wi.gov/publications/et2123/download?inline

WRS Performance (including Annual Returns, Rates and Adjustments): http://etf.wi.gov/wrs-performance

Buying Other Governmental Services: https://eft.wi.gov/publications/et2207/download?inline

EFT Member Education and Email Updates: http://etf.wi.gov/member-education

MissionSquare

The City of Oshkosh offers three voluntary retirement plans, including a 457 Deferred Compensation Plan, a 457 Roth Plan, and a Payroll Roth IRA plan, which are administered by MissionSquare. Participating in retirement plans can have a significant positive impact on your future. Eligible employees may enroll at any time by selecting a flat dollar amount to be deducted from each paycheck. 457 plan contributions are withheld on a pre-tax basis; 457 Roth and Payroll Roth IRA contributions are withheld on an after tax basis. Annual maximum contribution limits apply.

To enroll in the 457 Deferred Comp Plan or the 457 Roth Plan (plan number 300037) visit https://www.msqplanservices.org/myplan/300037.

To enroll in the Roth IRA Plan (plan number 705290) visit https://www.msqplanservices.org/myplan/705290

Review the comparison chart below to get started in the plan(s) that are best for you. You may also transfer or roll over other eligible retirement accounts to your 457 plan.

More information about MissionSquare and the investment options available can be found on their website at www.missionsq.org.

PLAN OVERVIEW	457 Plan #300037		Roth IRA # 705290
Feature	Pre-Tax	Roth	Roth
CONTRIBUTIONS			
Maximum Contribution (2023)	**Normal Limit: $22,500** **Age 50 Catch-Up: $6,500 ($29,000 total)** **OR** **Pre-Retirement Catch-Up: $22,500 ($40,000 total)** **All contribution limits apply to the combination of pre-tax and Roth contributions to the plan. Catch-up provisions cannot be combined in the same plan year. For each of the three years prior to the year you reach your normal retirement age, as defined in the plan and based on extent to which maximum contributions not made in previous years.**	**Same as 457 Plan Pre-Tax**	**$6,000** **Age 50 Catch-Up:** **$1,000 ($7,000 total)** **Pre-Retirement Catch-Up: N/A**
Contributions Reduce Taxable Income	**Yes**	**No**	**No**
Income Limits (2023)	**None. Participation is not limited by your annual income.**	**Same as 457 Plan Pre-Tax**	**Modified Adjusted Gross Income must be less than $208,000 (married filing jointly) or $140,000 (single or head of household)***
WITHDRAWALS			
Taxation of Withdrawals	**Withdrawals are subject to federal and, in most cases, state income taxes.**	**Withdrawals are tax-free if the requirements for a qualified distribution are met. Distributions of Roth assets are qualified if a period of five years has passed since January 1 of the year of your first Roth contribution (including rollovers), and you are at least 59½ years old (or disabled or deceased).**	**Same as 457 Plan Roth, except Roth IRAs also permit qualified distributions for a "first time" home purchase.**
Withdrawal Eligibility	**Upon separation from service with the plan sponsor. In-service withdrawal options (e.g., after age 70½, emergency withdrawals) may also be available.**	**Same as 457 Plan Pre-Tax**	**Withdrawals can be taken at any time. Contributions are always withdrawn first tax and penalty-free.**
Required Minimum Distributions (RMDs)	**After age 70½ or separation from service, whichever is later.**	**Same as 457 Plan Pre-Tax**	**None**
10% Early Withdrawal Penalty Tax	**457 plan contributions and associated earnings are not subject to the early withdrawal penalty tax. However, if you roll assets into your 457 plan from another type of account, the rolled-in assets are subject to the 10% early withdrawal penalty tax if withdrawn prior to age 59½, unless an exception to the penalty applies.**	**Same as 457 Plan Pre-Tax**	**Yes, the penalty may apply to the earnings portion of the withdrawal unless certain criteria are met.**

***For more information, view IRS Publication 590 or visit www.missionsq.org/ira**

MissionSquare *does not provide specific tax advice*

Important Legal Notices Affecting Your Health Plan Coverage

Patient Protections Disclosure

The City of Oshkosh 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, UMR 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 UMR at 800-826-9781 or www.umr.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from UMR 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 UMR at 800-826-9781 or www.umr.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:

UMR Group #76-415159 (Individual: 80% coinsurance and $1,000 deductible; Family: 80% coinsurance and $2,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 920-236-5110 or MBehnke@ci.oshkosh.wi.us.

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).

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, 2023. 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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
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. 5218

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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/ hone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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
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, 2023, 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)

Important Legal Notices Affecting Your Health Plan Coverage

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
City of Oshkosh is committed to the privacy of your health information. The administrators of the City of Oshkosh 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 Michelle Behnke - Human Resources Manager at 920-236-5110 or MBehnke@ci.oshkosh.wi.us.

HIPAA Special Enrollment Rights

City of Oshkosh Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Oshkosh 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 Michelle Behnke - Human Resources Manager at 920-236-5110 or MBehnke@ci.oshkosh.wi.us.

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.

Notice of Creditable Coverage

Important Notice from City of Oshkosh

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 Oshkosh 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 Oshkosh 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 coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current medical coverage through the City of Oshkosh, 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 Oshkosh 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 Oshkosh changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 01, 2024**
Name of Entity/Sender:	**City of Oshkosh**
Contact—Position/Office:	**Michelle Behnke - Human Resources Manager**
Office Address:	**215 Church Ave, PO BOX 1130** **Oshkosh, WI 54903-1130** **United States**
Phone Number:	**920-236-5110**

NOTICE REGARDING WELLNESS PROGRAM

The City of Oshkosh Health Risk Assessment (HRA) is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for glucose, triglycerides, LDL, HDL, Total Cholesterol, (and tobacco/nicotine if applicable) and complete weight, blood pressure, height, and Body Mass Index. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a 3% decreased medical insurance premium for completing the HRA. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive a 3% discount on the overall medical insurance premium.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources Manager, Michelle Behnke at 920-236-5110.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, and help improve our benefit offerings and wellness program services. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of Oshkosh may use aggregate information it collects to design a program based on identified health risks in the workplace, the City of Oshkosh HRA will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the health care provider(s) employed by our near site clinic in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources Manager, Michelle Behnke at 920-236-5110 or email mbehnke@ci.oshkosh.wi.us.

Important Legal Notices Affecting Your Health Plan Coverage

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Michelle Behnke.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name City of Oshkosh		4. Employer Identification Number (EIN) 39-6005563
5. Employer address 215 Church Ave, PO BOX 1130		6. Employer phone number 920-236-5110
7. City Oshkosh	8. State WI	9. ZIP code 54903-1130
10. Who can we contact about employee health coverage at this job? Michelle Behnke		
11. Phone number (if different from above)	12. Email address MBehnke@ci.oshkosh.wi.us	

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

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  An employee with the City of Oshkosh hired prior to July 1, 2011, who is regularly scheduled to work at least 975 or more hours per year, or if hired after July 1, 2011, is regularly scheduled to work at least 1200 or more hours per year.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Employee's spouse and their legal dependents up to age 26 are also eligible when the employee is covered and has elected to include their eligible dependent(s).

  ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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.