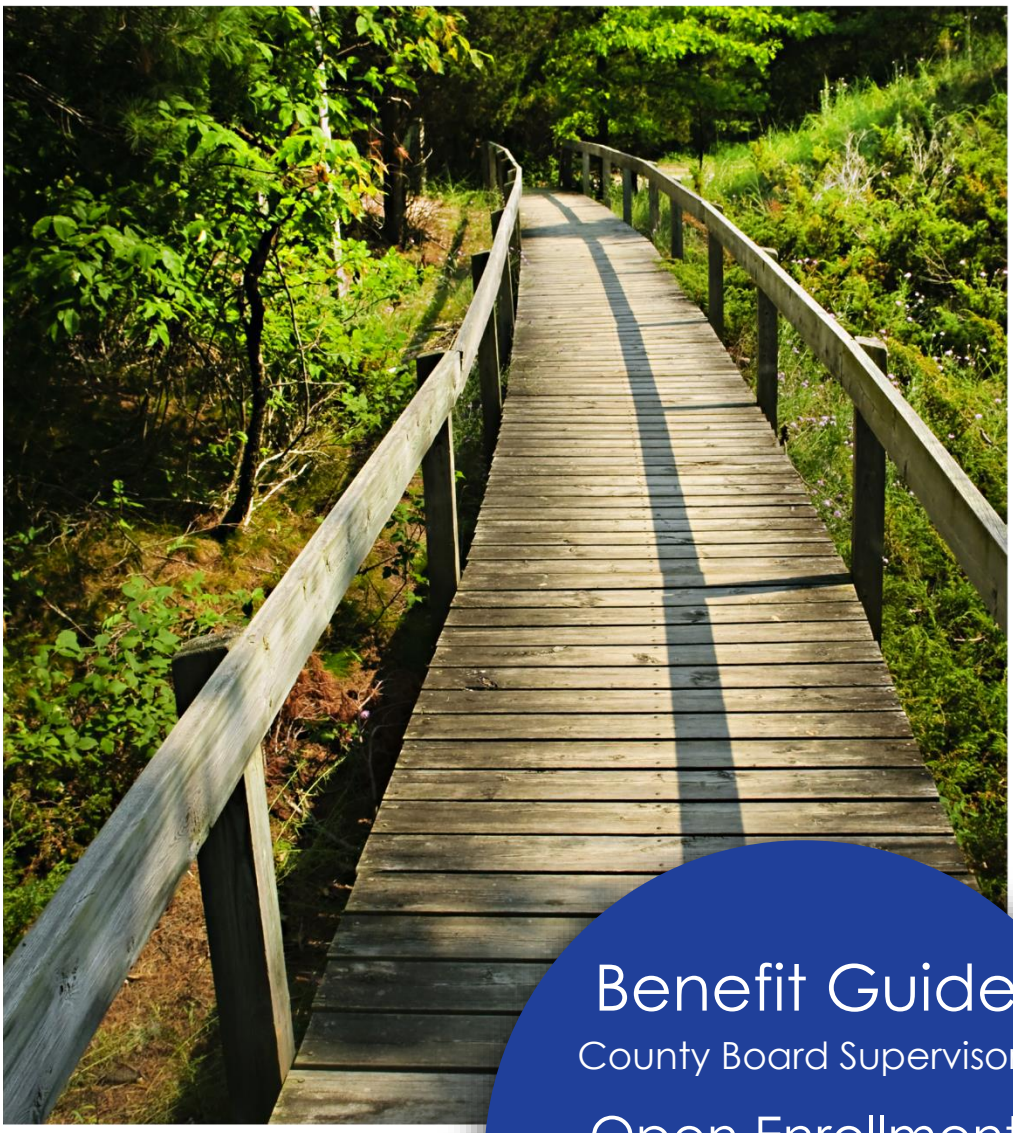
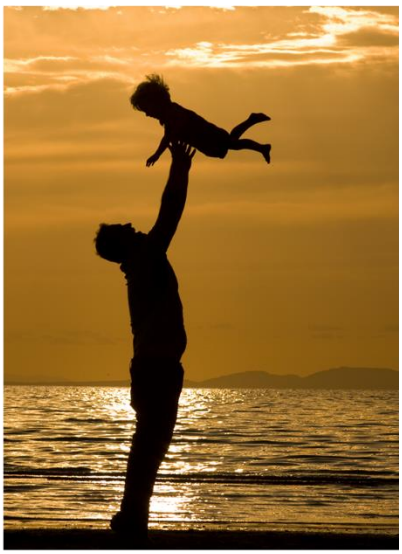




Benefit Guide

County Board Supervisors

Open Enrollment

October 1, 2020

through

October 31, 2020

2021

This presentation provides a highlight of the plans offered by the employer and in no way serves as the Summary Plan Description or plan document for the plans. If any discrepancies exist between this brochure and the plan documents, the plan documents shall govern. We reserve the right to modify any of these plans at any time.

WAUKESHA COUNTY
LEADING THE WAY

Benefits For You and Your Family

Waukesha County is excited to announce our 2021 benefits program, which we designed to help you stay healthy, feel secure, and maintain a positive work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

Enrollment Instructions

If you wish to make any changes to the following benefits in 2021, you must submit benefit elections for open enrollment.

- Health Insurance
- Dental Insurance
- Dependent Care FSA
- Health Care FSA

Important Instructions

Employees will complete open enrollment via paper election form. You can still login and view current elections via https://selfservicewauk.waukeshacounty.gov

Please Note: You must use either a laptop or PC when accessing this site. A tablet or smartphone will not work.

User Name and Password: Same as the username and password that you use to log into your PCs at work.

You do not need to be on the County network (intranet) to access the website. You can access the website from home as long as you use a laptop or PC.

All paper election forms must be return to Human Resources by October 31, 2020 if you are making any changes to benefits.

Coverage Changes During the Year

All new hire elections are final and open enrollment elections are final. You can only make changes to your elections if you experience a qualifying life event, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage.

A qualifying event must be reported to Human Resources within 30 days of the event.

Additional Education

Virtual Open Enrollment Meetings

Due to COVID-19, group meetings are virtual this year. Employees may attend an optional virtual Open Enrollment webinar. The meetings should last approximately 1 hour. A recording of the webinar will also be available for on-demand viewing. For the meeting information and webinar links, please visit www.waukeshacounty.gov/openenrollment

Virtual group sessions will be held at:

October 6, 2020	8:30 a.m. – 9:30 a.m.
October 8, 2020	1:00 p.m. – 2:00 p.m.
October 14, 2020	3:00 p.m. – 4:00 p.m.
On-Demand	24/7

Open Enrollment Resources

For plan documents and information visit:

Internet Site:
http://www.waukeshacounty.gov/openenrollment

Intranet Site:
https://connection.waukeshacounty.gov/ > HR > Benefits

Health Plan Coverage

What is the Premium Cost?

County Board Supervisors and the County Board Chairperson are only eligible to participate in the Choice Plus Health Plan.

Single Monthly Premium - $872.08

Family Monthly Premium - $2,352.83

What is changing for 2021?

- Medical premiums increasing
- In-Network plan design changes
  - Deductible/Out-of Pocket Increase
  - Rx Copay Increase
- Significant changes to how out-of-network claims are processed, including changes to deductibles and out of pocket
- Normally new health insurance cards are only sent when changes are made to covered members. This year, every enrolled subscriber should receive a new insurance ID card by early January 2021. Please know your member ID and group number are not changing.

How Do I Pay For My Benefits?

Depending on the level of coverage elected, premiums will be deducted from 24 pay checks and collected via ACH from a checking or savings account.

Important Terms to Know

Deductible - A specified amount of money that an insured must pay before the medical insurance plan will pay a claim. F

Coinsurance - The percentage an insured must pay against a claim after the deductible is satisfied.

Copayment - A fixed dollar amount paid by a patient to the provider of service, typically before receiving the service. For example, you would pay a copay for prescriptions drugs under the Choice Plus plan.

Out-of-Pocket Maximum - The most money you will pay during a policy period for covered health care services and prescription drugs. After you spend this amount on deductibles, copayments and coinsurance, the health plan pays 100% of the costs of covered benefits.

Health Plan Coverage

Plan Design Summary:

	Benefits	In-Network	Out-of-Network
1.	**Lifetime Maximum**	Unlimited	Unlimited
2.	**Annual Deductible (Does not include Rx co-pay)**	$800 person / $2,400 family	$1,600 person / $4,800 family
3.	**Coinsurance***	80%/20% after deductible 70%/30% after deductible when Tier 1 Provider Available but not used	60%/40% after deductible
4.	**Coinsurance Out-of-Pocket Expense (Does not include Rx co-pay)**	$1,800 single / $4,200 family	$8,400 single / $15,200 family
5.	**Total Out-of-Pocket Maximum (deductible + co-insurance +Rx co-pay)**	$2,600 single / $6,600 family	$10,000 single / $20,000 family
6.	**Preventive Care**	100% for approved services	60%/40% of eligible expenses
7.	**Prescription Drugs**	$10 – Tier-1 / $35 – Tier-2 / $50 – Tier-3 / $200 – Tier-4	NOT COVERED
8.	**Hospitalization**	80%/20% of eligible services*	60%/40% of eligible expenses
9.	**Surgical – Medical Care**	80%/20% of eligible services*	60%/40% of eligible expenses
10.	**Physician Visits in Hospital**	80%/20% of eligible services*	60%/40% of eligible expenses
11.	**Maternity**	80%/20% of eligible services*	60%/40% of eligible expenses
12.	**X-Ray and Lab Tests**	80%/20% of eligible services*	60%/40% of eligible expenses
13.	**Radiation Therapy**	80%/20% of eligible services*	60%/40% of eligible expenses
14.	**Emergency Care**	80% of eligible expenses, if authorized*	80% of eligible expenses, if authorized
15.	**Physician Office**	80%/20% of eligible expenses*	60%/40% of eligible expenses
16.	**Physical, Speech, and Occupational Therapy**	80%/20% of eligible expenses (Maximum of 60 days/calendar year)*	60%/40% of eligible expenses (Maximum of 60 days/calendar year)
17.	**Immunizations and Injections**	80%/20% of eligible expenses*	60%/40% of eligible expenses
18.	**Durable Medical Equipment**	80%/20% of eligible expenses*	60%/40% of eligible expenses
19.	**Allergy Care**	80%/20% of eligible expenses*	60%/40% of eligible expenses
20.	**Ambulance**	80%/20% of eligible expenses*	80%/20% of eligible expenses
21.	**Oral Surgery**	Specific oral surgical procedures covered at 80% of eligible expenses*	Specific oral surgical procedures covered at 60% of eligible expenses
22.	**Skilled Nursing Facility**	80%/20% of eligible expenses, 30 days/disability*	60%/40% of eligible expenses, 30 days/disability
23.	**Hearing Exams**	80%/20% of eligible expenses*	NOT COVERED
24.	**Mental Health and Chemical Dependency Services**		
	A. Outpatient Hospital	80%/20%*	60%/40%
	B. Inpatient Hospital	80%/20%*	60%/40%
	C. Transitional Treatment	80%/20%*	60%/40%
25.	**TMJ Syndrome**	80%/20% of eligible expenses for approved services. Certain limitations apply*	60%/40% of eligible expenses for approved services. Certain limitations apply.
26.	**Chiropractic Care**	80%/20% of eligible expenses. Limit 24 visits/year*	60%/40% of eligible expenses. Limit 24 visits/year
27.	**Dependent Child Coverage**	A dependent child includes the employee or spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom the employee or spouse are legal guardian. Coverage is terminated the day the child turns 26.	

This outline is intended to provide a brief overview of the health insurance plans available to you. It should not be considered a complete source of information. For a complete description of the benefits, limitations, exclusions, terms and conditions, please refer to the master plan documents, which are available for review in the Department of Administration, Human Resources. In a conflict between this outline and the master plan documents, the master plan documents control.

Ways to Save on Care

Employee Health & Wellness Center

The **Health & Wellness Center** is on-site health clinic for employees and family members enrolled in the Health Insurance. Employees and dependents (ages 2+) may use the Health & Wellness Center.

Scheduling Options:
Waukesha Employee Health & Wellness Center
(262) 896-8420 Direct
(866) 959-9355 Scheduling Line
Online: patientportal.yourhealthstat.com

Information:
Website: http://bit.ly/WEHWC3
Facebook: @WaukeshaEmployeeHealthandWellness

Hours

Monday, Wednesday	7:00 AM - 7:00 PM
Tuesday, Thursday, Friday	7:00 AM - 6:00 PM
Saturday	8:00 AM - 1:00 PM
Sunday	Closed

Location

615 W Moreland Blvd
Waukesha, WI 5318

Services

Disease Management
- Manage & Prevent Diabetes
- Cholesterol
- Blood Pressure

Lifestyle Coaching / Health Coaching
- Weight Loss
- Tobacco Cessation

Preventative Services
- Routine annual physical exam (ages 6+)
- Preventative Screenings

Acute Illness
- Sore throat
- Ear & sinus infections
- Cold, Flu, etc.
- Mole Removal

Physical Therapy
- Early morning to late afternoon appointments available

Minor Injuries
- Muscle and Joint Pain
- Sprains and Strains
- Cuts and stitches

Lab Work
- Administer shots / vaccinations
- Order, conduct, interpret and consult on routine diagnostic lab work
- Can complete lab draw with orders from outside provider

Medication
- Dispense Pre-Packaged Medications
- Prescribe Medication

Coordination with outside providers

Referrals to Specialist

Virtual Visits

2021 Costs

Choice Plus Plan:	$0 (includes Preventative, Non-Preventative, & Physical Therapy).
Medication:	$2.00/package for all dispensed medications for both health plan options. Dispensed available ACA preventative medications are $0-Cost.

Ways to Save on Care

Where to Go For Care

Did you know that there is a large cost difference to receive health care based on where you go to receive it? With a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA), you pay the full cost for a visit prior to meeting the deductible. For those instances when you need to make a quick choice about where to get the medical attention you need, it is important to not only map out the closest medical location to you, but also be aware of the types of facilities nearby, their hours of operation, and the costs associated with them.

- $30 — Health and Wellness Center
- $70 *Or less — Virtual Visits
- *About $70-$100 — Convenience Care Clinic
- *About $130-$200 — Primary Care Physician
- *About $300-$600 — Urgent Care
- *About $600-$1400 — Emergency Room

Lowest Severity
Lowest Cost

If you aren't sure …
Start with UHC's Advocate4Me.
Call the Phone # on the back your ID card.

*Please note: These dollars are for illustrative purposes only. Costs may vary based on where services are rendered.

Radiology

MRIs and CT Scans can range anywhere from $1,000 to $3,500 in hospital facilities. Independent radiology centers cost on average 25-30% less than hospital based MRI services and can be as low as $600.

Smart Choice MRI has locations in Appleton, Green Bay, Milwaukee, Richfield, La Crosse, Waukesha, Kenosha. Call 844-633-3674 to schedule an appointment.

MH Imaging has locations in Milwaukee, Kenosha and Racine.

Colonoscopies

Outpatient surgery centers, also called ambulatory surgery centers (ASC) are often a lower cost than a hospital for procedures like colonoscopies.

Did you know that Preventive Colonoscopies are covered at 100%?

Ways to Save on Care

Low Cost Prescription Drugs

Did you know that the Health and Wellness Center has certain prescriptions available for $2, and for $0 if on the ACA preventive drug list? For a full list of these prescriptions, please see the Wellness Center website on page 9.

Medication Refill Process at the Health & Wellness Center:

1. Schedule an initial visit with a provider. The provider needs to evaluate the medication before prescribing. In some cases, the provider will be able to dispense up to three (3) months of medication at this visit. The fee for dispensed medication is $2.00 per bottle. Depending on your health plan, you may be charged a non-preventative fee for the initial visit.

2. If a refill is requested, the patient schedules a medication refill visit. This is a check-in with the provider so they can dispense the medication. Since it is not a pharmacy, patients need to see the provider, at least briefly so they can dispense the medication to the patient directly. There is no office visit fee for the medication refill appointment itself.

3. It is up to provider discretion if they are able to refill a prescription or if they need to evaluate a patient further to determine if medication is working or needs adjusting. This may require a follow-up visit (blood test, BP check, etc.,) and may require a more comprehensive visit in that instance. For some patients this could be 90 days, 6 months, or yearly, but would not be every refill.

4. If you are seen by one of our providers and your medication is not included in the list, the providers will be able to write you a script. It can be sent electronically to your preferred pharmacy for pick up. Regular pharmacy rates will apply.

Ways to Engage in Your Health Care

Accessing High Quality Care

Studies show that people who actively engage in their healthcare decisions have fewer hospitalizations, higher utilization of preventive care and overall lower medical costs. Premium designation makes it easy for you to find doctors who meet national standards for quality and local market benchmarks for efficiency.

Members that choose to utilize in-network providers who are Tier 1 Providers (indicated by TWO Blue Hearts) will pay 80% coinsurance once the deductible is met. Members that choose to use in-network providers that are not considered Tier 1 when otherwise available will pay a 70% coinsurance amount for those services.

Only physicians (primary and specialty) are evaluated under this program. In-network hospitals and facilities will be paid as a Tier 1 providers. Providers and their premium designation status is identified on the ***myuhc.com*** member site.

What do the Two Blue Hearts Mean?

The UnitedHealth Premium Program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. Not all *specialties* are evaluated at this time. So, when searching for a provider, you must decipher whether it is the physician who is not evaluated or if it is the specialty which is not evaluated. The table below outlines the designations associated with the hearts. If a physician does not have two blue hearts, it does not mean that he or she provides a lower standard of care. It could mean that the data available for this physician was not sufficient to include the doctor in the program.

Money Saving Tip

Did you know you could be paying up to 36% less for care by checking your costs on the myuhc.com website?

UnitedHealth Premium® United in care.

UnitedHealthcare®

Premium Designation	Displayed Explanation
Premium Care Physician ♥♥	The physician meets the UnitedHealth Premium program quality and cost-efficient care criteria.
Quality Care Physician ♥♡	The physician meets the UnitedHealth Premium program quality care criteria but does not meet the program's cost-efficient care criteria.
	The physician meets the UnitedHealth Premium program quality care criteria but is not evaluated for cost-efficient care.
Not Evaluated For Premium Care ♡♡	The physician's specialty is not evaluated in the UnitedHealth Premium program.
	The physician does not have enough claims data for UnitedHealth Premium program evaluation, so the physician is not eligible for the Premium Care Physician designation.
	The physician's program evaluation is in process.
Does Not Meet Premium Quality Criteria ♡♡	The physician does not meet the UnitedHealth Premium program quality criteria, so the physician is not eligible for a Premium designation.

Ways to Engage in Your Health Care

Weight Management with Real Appeal

Real Appeal is a weight loss and healthy living program that can help you and your family take small steps that lead to big results.

Based on decades of clinical research, Real Appeal helps you lose weight and reduce your risk of developing diseases like diabetes and cardiovascular disease. Real Appeal members who attended 4 or more sessions during the program lost 10 pounds on average.

Health plan participants at the County (employees and spouses) are invited to join the program voluntarily and at no cost.

How does the program work?

Once participants enroll, they will meet with a personalization expert - from a smart phone, tablet or computer - who will customize a program that suits participants lifestyle and targets desired weight loss goals.

On average, participants lose 10 pounds after attending just 4 online classes!

Next, Real Appeal will give participants access to a transformation coach to meet with virtually for the next year to offer support and help participants stay on track.

24/7 Convenience

Helping you stay accountable to your goals

- Food, activity, weight and goal trackers
- Unlimited access to digital content
- Your online group class, which is designated to help you build camaraderie and accountability with others in the program.
- Weekly health tips from celebrities, athletes and health experts.

Success Kit

Resources to help you kick-start your weight loss and keep yourself on the road to results. Your kit will be delivered after your first class.

It includes:

- Step by step Success Guides
- Workout DVDs
- Quick and simple recipes
- Nutrition guide
- And much more.

Real Appeal®

UnitedHealthcare®

Ways to Engage in Your Health Care

Cancer Support Program

If you are diagnosed with cancer, our partnership with UnitedHealthcare and The Cancer Support Program (CSP) offers you a source of information and guidance navigating the health care system.

Through dedicated assistance from oncology nurses and social workers, the program is intended to enhance your quality of care and quality of life.

97% of overall members are very satisfied/satisfied

Dedicated assistance

Program nurses specializing in oncology serve as one contact for you in the program, helping you make informed decisions about your cancer care. Specialized cancer nurses are supported by an entire team of cancer specialists. Through comprehensive case management services, you can receive one-on-one help with a range of cancer-related issues. Additional support from specialized social workers offer your members and their loved ones help with family, work, financial and other needs.

Cancer Centers of Excellence Network

UnitedHealthcare identifies top-quality cancer centers across the country to participate in the Cancer Centers of Excellence (COE) network. These centers provide high-quality, appropriate and cost-effective care, and are reviewed annually to ensure they continue to meet the high standards for which they were originally selected.

Cancer COE locations.

Your Claims Concierge

Navigating the health care system can be difficult. Our benefit consultants at HNI Risk Advisors have a dedicated advocate to help resolve issues on behalf of you or your family members.

In addition to the services provided by your insurance carriers, your dedicated claims concierge can provide help to you and your spouse for:

- Claim Issue Assistance
- Insurance Carrier or Provider Issues
- Insurance Product Education
- Insurance ID Cards
- Online Assistance
- General Questions
- Provider Directory Searches
- Plan Design Information
- COBRA/State Continuation
- Individual or Short-Term Policies

MARGARITA LEWISON
CLAIMS CONCIERGE
p: 262.641.5858

mlewison@hni.com

Hablo Espanol

Ways to Engage in Your Health Care

Other UnitedHealthcare Resources

myuhc.com

Register on myuhc.com to find tools and information to help you manage and improve your health and save money.

- Track Claims and expenses for your family
- Check the status of a claim
- Find Care and Costs
- Find providers
- See your account balance for your Optum HSA
- Print a temporary ID card

UnitedHealthcare App™

Download the mobile app to take the features of myuhc.com on the go with your smartphone or tablet.

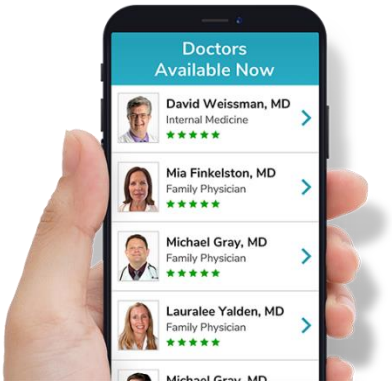
Find Care and Cost

Step 1: Visit myuhc.com or the UnitedHealthcare App. Once you are logged in, click "Find Care & Costs" on the main dash.

Step 2: Search for a condition or treatment. Try phrases like colonoscopy or MRI. Then hit the search button.

Step 3: Select a provider and/or facility.

Step 4: Click View Full Estimate. You can see your Final Estimate, which includes estimated costs from the doctor or facility you have chosen, along with up-to-date out-of-pocket estimated costs, based on your benefits and current level of coverage.



Virtual Visits

Dental Coverage

Dental insurance is provided through Delta Dental of Wisconsin. You have two choices of Dental Plans:

- **The Standard Plan:** This plan has more provider choices, costs less, but has a lesser benefit.
- **The Exclusive Plan:** This plan has limited coverage choice to Delta's PPO providers only, has a better benefit, but costs more. If the provider is not in the PPO network, you will not have coverage. The cost for this plan is increasing 4% for 2021.

www.deltadentalwi.com

Delta Dental PPO: These providers have signed a contract agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these providers agree to fees approved by Delta Dental, they receive payment directly from Delta Dental. You will receive the greatest discount from PPO providers.

Delta Dental Premier: These providers have signed a contract agreeing to capped fees. The capped fees tend to be higher than what a PPO network dentist might charge.

If you see an out-of-network provider, you will have the highest out-of-pocket expense. Whenever possible, see an in-network provider to lower your out-of-pocket costs.

Premium Cost Sharing

Payroll deductions for dental insurance by default is pre-tax unless an employee notifies Human Resources otherwise. Employee dental insurance contributions are deducted from the first two paychecks of the month or from 24 paychecks in the year.

	Delta Dental Standard		Delta Dental Exclusive	
	Single	Family	Single	Family
Total Monthly Premium	$29.80	$103.61	$54.52	$168.85

Comparison of Benefits for Dental Plans

For a complete description of benefits, refer to each plan's summary plan description or certificate of coverage.

BENEFITS HIGHLIGHTS	DELTA DENTAL STANDARD PLAN	DELTA DENTAL EXCLUSIVE PLAN
A. DELTA DENTAL NETWORK	Delta Dental PPO, Delta Dental Premier or choice of provider. Claim benefit payments are calculated using the Maximum Plan allowance.	Delta Dental PPO only Claim benefit payments are calculated using the PPO Fee Allowance.
B. MAXIMUM ALLOWANCE	$1,250 per person per calendar year.	Unlimited maximum per person per calendar year.
C. DEDUCTIBLE	$25.00 individual deductible – Maximum of $75.00 per family	No deductible
D. PRE-CERTIFICATION OF BENEFITS	Delta Dental of Wisconsin recommends a predetermination of benefits for treatment plans that include crowns, fixed bridgework, implants, or dentures.	Delta Dental of Wisconsin recommends a predetermination of benefits for treatment plans that include crowns, fixed bridgework, implants, or dentures.
E. DIAGNOSTIC 1. Bitewing x-rays 2. Full mouth x-rays	No deductible applied. 100% Limited to once in a benefit year. 100% Limited to once every 60-months.	 100% Limited to once in a benefit year. 100% Limited to once every 60-months.
F. ORAL EXAMINATIONS	No deductible applied. 100% Limited to twice per benefit year.	 100% Limited to twice per benefit year.
G. PREVENTIVE 1. Application of topical fluoride 2. Prophylaxis-cleaning of teeth 3. Space maintainers 4. Topical Sealants	No deductible applied. 100% Limited to twice per benefit year under age 19. 100% Limited to twice per benefit year. 100% Limited to covered persons under age 16. 100% Covered on permanent molars under age 18. Once application per tooth per lifetime.	 100% Limited to twice per benefit year under age 19. 100% Limited to twice per benefit year. 100% Limited to covered persons under age 16. 100% Covered on permanent molars under age 18. Once application per tooth per lifetime.
H. ANCILLARY 1. Local anesthetics and general anesthetics, if medically necessary. 2. Injection of antibiotics 3. Nitrous oxide-oxygen sedation 4. Emergency treatment of pain 5. Denture repairs and adjustments, recementing of crowns or bridges	Deductible Applies 100% 100% Not covered 100% 50%	 100% 100% Not covered. 100% 100%
I. RESTORATIONS 1. Amalgam fillings and composite fillings on anterior teeth. 2. Cast metal (gold or non-precious metal) onlays, inlays, crowns	Deductible Applies 100% 50%	 100% 70%
J. ENDODONTICS— Root canal treatment and pulpal therapy	Deductible Applies 80%	 100%
K. PERIODONTICS— Treatment for diseases of gums and tissues of the mouth	Deductible Applies 80%	 100%
L. ORAL SURGERY Including simple extraction	Deductible Applies 80% Will not duplicate regular health insurance surgical-medical benefits.	 100% Will not duplicate regular health insurance surgical-medical benefits.
M. PROSTHETICS— Bridges, partials, dentures, implants	Deductible Applies 50%	 70%
N. ORTHODONTICS— Braces	No Deductible Applies 50% Limited to dependent children under age 19 and lifetime maximum of $1,500.	$650 Deductible 100% No age limits. No lifetime maximum.
O. Evidence-Based Integrated Care Program	Additional cleanings and/or topical fluoride applications for certain medical conditions.	Additional cleanings and/or topical fluoride applications for certain medical conditions.

*The statements in this comparison are subject to the terms and conditions of the dental master contracts.

The Healthcare FSA

The Healthcare FSA is a flexible spending account (FSA) authorized under Section 125 of the Internal Revenue Code. This plan allows you to set aside money through pre-tax payroll deductions to pay for health care expenses that are not covered under your group health, dental, or vision plans such as deductibles, co-insurance, co-pays, certain over-the-counter medications, and other uncovered expenses. The minimum annual election is $260, and the maximum annual election is $2,750 for 2021 (at time of guidebook publication).

<u>If you are enrolled in the High Deductible Health Plan, you may not enroll in the Healthcare FSA</u>.

When making your election, keep in mind that preventive services are covered at 100%.

1. Plan Year — The plan year begins January 1 and ends December 31. You will be required to re-enroll in the plan each year during the annual open enrollment period if you wish to make pre-tax payroll contributions into your account.

2. Forfeiture — Employees have up to ninety (90) days following the end of each plan year to request reimbursement for qualified health care claims. In order to qualify, the covered service or expense must be incurred during the plan year (January 1 – December 31). The employee will forfeit any unreimbursed fund balances following this period. Therefore, it is very important that employees carefully evaluate the amount of contributions they elect under this plan.

3. Administrative Expenses — The plan administrator charges a fee to administer this program. Waukesha County will pay this fee on your behalf.

4. Eligible Expenses — Eligible health care reimbursement expenses are those qualified medical or dental expenses that are not covered, or only partially covered under your insurance plans. For more information, refer to IRS Publication 502 (Medical and Dental Expenses) located on the Intranet.

If you choose not to enroll and participate in either of these plans for 2021, you will be required to wait until the next annual open enrollment period, unless you experience a qualifying event.

Employee Benefits Corporation

Dependent Care FSA

Dependent Care FSA is an IRS-approved plan that allows you to deduct up to a maximum of $5,000 (or $2,500 per year if married and filing separate federal income tax returns) per year from your earnings for employment related child and/or elder care expenses before taxes are taken out. The minimum annual deduction is $260. The tax savings in this plan may be greater than the savings on the standard Federal Tax Credit. The County pays the administrative fees for every employee in the plan.

How does it work? — The following illustrates how this program works. Keep in mind that the Internal Revenue Code governs many of the requirements.

1. Employees must enroll during Open Enrollment prior to the plan year effective date (January 1, 2021). Current participants are required to complete a new form to re-enroll each year. You must list the total dollar amount of your dependent care expenses for each pay period in 2021. Please note that if you do not use the total amount you have allocated by the end of the calendar year, the unused dollars will be forfeited.

2. Just prior to the beginning of the year, you will receive a welcome packet including your first claim form. You will complete your claim forms, listing the dependent care expense and service period, and submit them throughout the year for reimbursement. Claim forms may be submitted as often as daily. However, they may not be submitted until after the dependent care services have been rendered.

3. You pay your dependent care provider and then submit the claim form for reimbursement.

4. The amount of your dependent care expense will be deducted from each of your paychecks on a pre-tax basis.

5. Other features of this program include direct deposit where your reimbursement will be electronically deposited to your bank account. Also, your claim forms can be faxed, mailed, or E-claims for reimbursement.

Compliance Notifications

Summary Benefit Comparison and Summary Plan documents are available on the Waukesha County Intranet and Open Enrollment internet page. If you wish to receive a paper copy, you may contact Human Resources at 262-548-7044.

Waukesha County is providing you with the following information to ensure you are aware of federal notice regulations as they relate to your group health plan. We have posted on the intranet the health care reform notices, the initial benefits notices that are typically sent upon new employment, as well as, the required annual notices. These notices are intended to notify you of your rights and may not address all regulations in detail.

If you would like a hard copy of the documents, please contact Human Resources at 262-548-7044. Please share this information with your dependents and/or plan beneficiaries. Included below is a listing of the notices with a brief description of each:

- CHIP/CHIPRA – two required notices. Notice that outlines when eligible employees or dependents that are eligible but not enrolled, will be permitted to enroll if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP. Second notice outlines the contact information where employees may inquire about CHIP.

- General Notice of COBRA Continuation Coverage Rights - Notice to covered employees, covered spouses, and covered dependents of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.

- FMLA - Notice explaining the Family and Medical Leave Act.

- Health Insurance Marketplace Coverage Options - Notice explaining the availability of insurance coverage through the Health Insurance Marketplace (Exchange).

- HIPAA Privacy Notice - Notice of Privacy Practices and an explanation of your privacy rights.

- HIPAA Portability Rights and Special Enrollment Rights - The Notice of Special Enrollment Rights outlines your right to join the plan at a future date if you should lose coverage due to a qualifying event.

- Medicare Part D Notice (Individual Creditable Coverage Disclosure Notice Language) – by October 15th each year. Provided to active and retired employees and to Medicare Part D eligible individuals. This creditable coverage notice alerts you as to whether or not your prescription drug coverage is comparable to the Medicare Part D coverage.

- Newborns' and Mothers' Health Protection Act - Notice regarding hospital stays in conjunction with maternity.

- USERRA - Notice of rights, benefits, and obligations of persons entitled to USERRA.

- Women's Health and Cancer Rights Act - Notice of the availability of benefits for the required coverage and information on how to obtain a detailed description.

Open Enrollment: October 1 – 31, 2020

This presentation provides a highlight of the plans offered by the employer and in no way serves as the Summary Plan Description or plan document for the plans. If any discrepancies exist between this brochure and the plan documents, the plan documents shall govern. We reserve the right to modify any of these plans at any time.