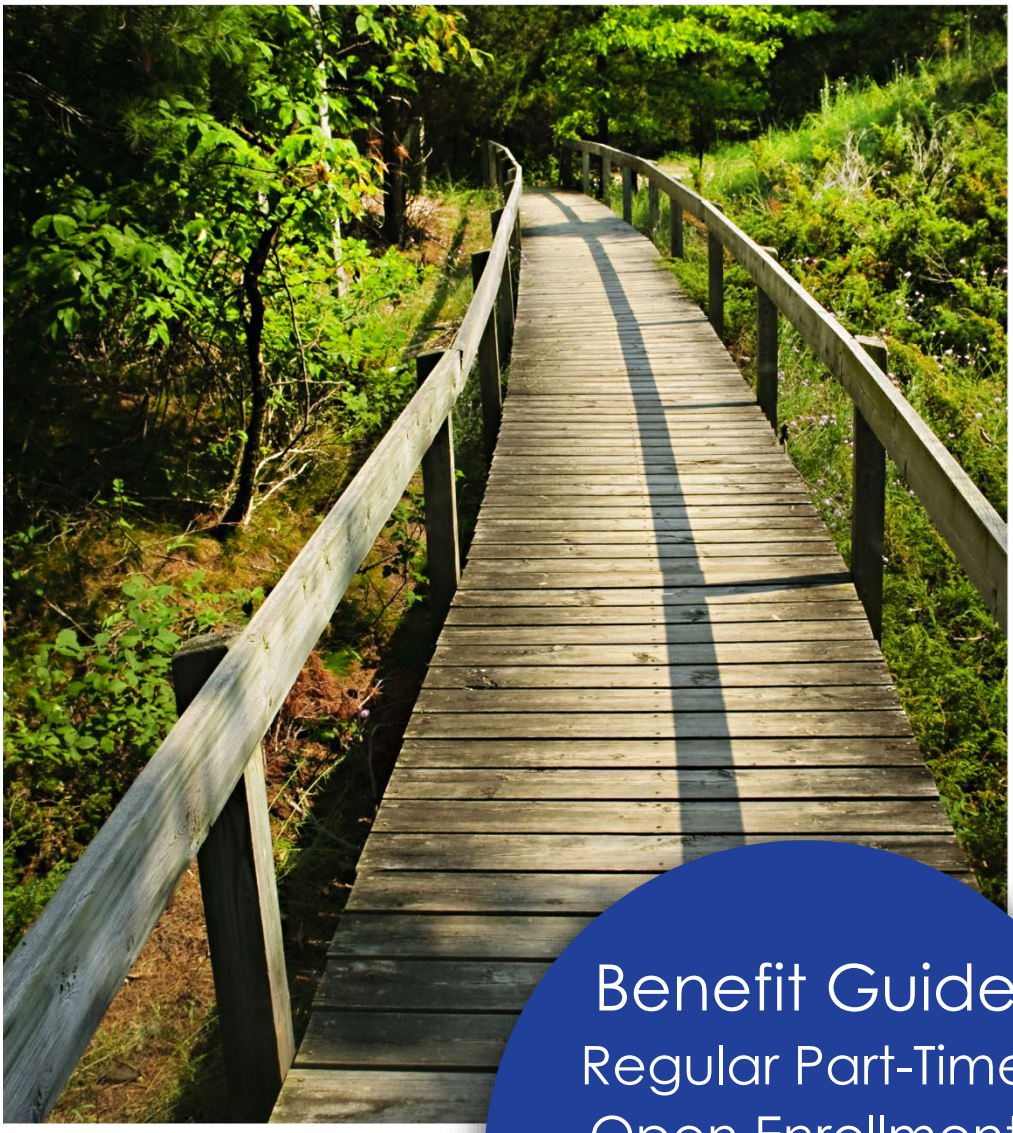
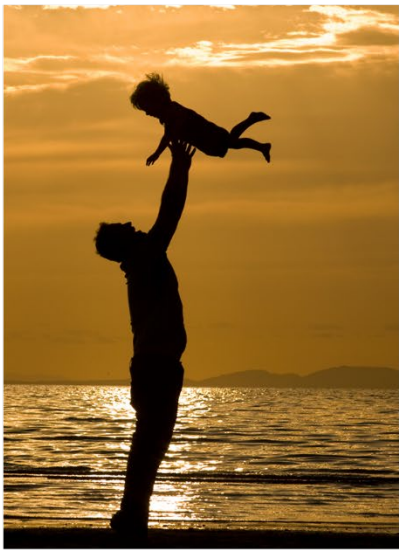




Benefit Guide

Regular Part-Time

Open Enrollment

October 2, 2023

through

October 20, 2023

2024

WAUKESHA COUNTY
LEADING THE WAY

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.

Benefits For You and Your Family

Waukesha County is excited to announce our 2024 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

All benefit eligible employees must elect or waive benefits during open enrollment.

If you wish to have any of the following benefits in 2024, you must submit benefit elections for open enrollment.

- Health Insurance
- Dental Insurance
- Vision Insurance
- Voluntary Supplemental Term Life Insurance
- Health Savings Account (via Self Service)
- Dependent Care FSA
- Health Care FSA
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

Important Instructions

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

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

All paper election forms must be returned to Human Resources by October 20, 2023.

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.

Education Sessions

Education Sessions regarding new program offerings will be held virtually. For the meeting information and webinar links, please visit www.waukeshacounty.gov/openenrollment

HERO Education Sessions

October 3, 2023	10:00 a.m. – 10:30 a.m.
October 3, 2023	3:00 p.m. – 3:30 p.m.
October 4, 2023	3:00 p.m. – 4:00 p.m.
Recording	On-Demand

Curally Overview	On-Demand
Open Enrollment Overview	On-Demand
Voluntary Benefits Overview	On-Demand

Open Enrollment Resources

For plan documents and information visit:

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

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

2024 Changes:

- Health insurance premiums increasing 2.5% for both health plans.
- Delta Exclusive premiums increasing 7%.
- Health Expense Reimbursement Option (HERO) plan being offered.
- Partnership with Curally to assist health insurance members with chronic condition management.
- 2024 Health Savings Account annual maximum limits increasing.

Health Insurance

How Do I Pay for My Benefits?

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

Who is Eligible for the Health Plan?

All regular full-time employees are eligible to participate in the Waukesha County health plan. Eligible employees may also enroll their legal spouse and dependent children. A dependent child may be the natural child, stepchild, legally adopted child, child placed for adoption, or other children for whom the employee has permanent legal custody.

Only employees and dependents currently enrolled in health insurance may enroll in the HERO plan.

Health Expense Reimbursement Option (HERO Plan)

administered by 44North

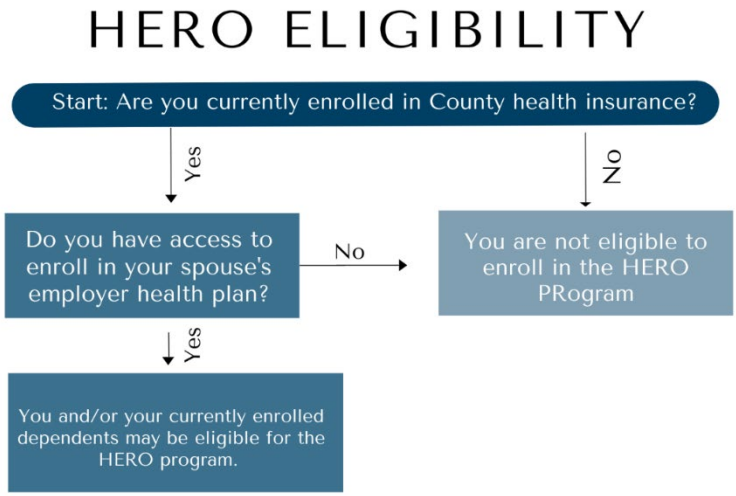
If you are on the Waukesha County Health Plan today, and if you or your family have access to and select coverage through your spouse or other employer sponsored coverage, Waukesha County will reimburse you, and any other family member currently on the Waukesha County Plan up to 100% of your in-network medical and prescription claims on that plan. Reimbursement is limited to ACA out of pocket maximum of $9,450 for an individual and $18,900 for a family (2024 limits).

What does HERO Reimburse?

In a typical employer health insurance plan, an employee and their family will have coverage for doctor and hospital visits, prescription drugs, wellness care and surgical procedures. However, while the plan covers these expenses, the employee and their family generally have out-of-pocket expenses, like deductibles, copays and coinsurance. HERO is designed to cover all in-network costs incurred by the employee and their family by reimbursing you directly for these expenses. The HERO plan will not reimburse claims for plan exclusions, out-of-network expenses, employee premiums, or spousal surcharge costs.

Who is eligible to participate?

Employees, spouses and dependents with access to other employer-sponsored coverage through a spouse AND who are currently enrolled in the Waukesha County Health Plan are eligible for the HERO plan in 2024. All members who have previously waived coverage and not currently enrolled are not eligible for the HERO plan.



What to expect

When you enroll in the HERO plan, a 44North Patient Advocate will contact you to:

1. Personally welcome you to the plan. You will receive two phone call attempts and one email attempt.
2. Collect information about your spouse's or other employer sponsored plan coverage to help ensure you are receiving the maximum benefit between both your medical plan and the HERO plan.
3. Explain the process for submitting a claim for eligible expenses.

It is important to respond to your Patient Advocate timely to ensure the smoothest coordination of your benefits.

How do I get reimbursed?

After incurring an eligible medical or prescription expense that was incurred on or after January 1, 2024, you must submit your claim for reimbursement by email, mail or fax to 44North. You will need to include a claim form and IRS- required documentation of the expense, e.g. Explanation of Benefits. During your initial welcome call with your Patient Advocate, you will receive a claim form and instructions on how to submit a claim and what documentation is needed. A Direct Deposit Authorization Form is available for download at www.waukeshacounty.gov/openenrollment.

What if I have questions?

For questions regarding eligibility or HERO plan benefits contact 44North at 855-306-1099.

What is the cost to participate in the HERO Plan?

You will need to pay the health insurance premiums through your spouse's employer health insurance program. Employees who are completely no longer enrolled in the Waukesha County health plan by enrolling in the HERO plan will not pay a premium to Waukesha County for health insurance coverage.

Can I still access the Waukesha Employee Health & Wellness Center?

Yes, those enrolled in the HERO program may still utilize the Health & Wellness Center. Payments made within the Waukesha Employee Health & Wellness Center would be out-of-network for your other coverage and claims will not be submitted to another carrier besides the County's health plan carrier. The office visit fee schedule (Pg 16) will be similar to the High Deductible Health Plan.

Can I enroll in HERO and fund my Health Savings Account?

No. Not if you wish to be reimbursed with first dollar coverage through the HERO Plan. You must suspend contributions into your HSA plan. However, you can use any previously deposited funds into the Health Savings Account to pay for any initial expenses until the reimbursement is processed. Should you wish to maintain an HSA with contributions during the year, you must speak with a HERO representative on what your HERO deductible responsibility must look like under IRS rules, before the HERO plan would reimburse you.

What if my spouse's Open Enrollment is different from January 1st?

Many employers who have a non-calendar year Open Enrollment period allow changes to accommodate a spouse's enrollment changes occurring during their employer's Open Enrollment, but they are not required to do so. Employees should check with their spouse's employer to confirm they will be able to enroll for January 1st.

Health Plan Coverage

Nothing is more important than your overall health and well-being. That's why your benefits program provides medical insurance and access to our Health and Wellness Center to help keep you and your family healthy.

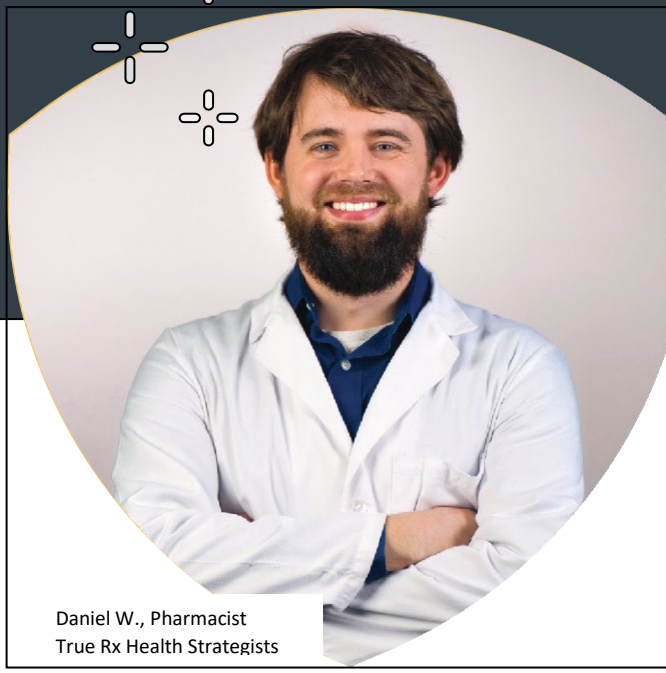
Please note: WDSLU Employees and Employees hired after 1/1/2017 are only eligible for the HDHP option.

In-Network Benefits Shown	Choice Plus		HDHP	
	Single	Family	Single	Family
Annual Deductible	$800	$2,400	$2,100	$4,200
Co-Insurance Percentage after deductible: Tier 1 Provider Used	80%/20%		80%/20%	
Co-Insurance Percentage after deductible: Available Tier 1 Provider Not Used	70%/30%		70%/30%	
Out of Pocket Maximum (Deductible+ Coins.+ Rx Copays)	$2,600	$6,600	$3,250	$6,500
Waukesha Employee Health & Wellness Center	**Preventive: $0 Non- Preventive $0 Physical Therapy: $0**		**Preventive: $0 Non- Preventive $28 Physical Therapy: $28 After Deductible Met then copay is $0**	
Preventive Care	100%		100%	
UHC Approved Virtual Visit Provider	$10		Deductible Then $10 copay	
Primary Care Office Visits *All other services other than office exam subject to deductible and coinsurance*	$35 copay Tier 1 PCP $50 copay Non Tier 1 PCP		Deductible Then copay applies $35 copay Tier 1 PCP $50 copay Non Tier 1 PCP	
Specialist Office Visits *All other services other than office exam subject to deductible and coinsurance*	$70 copay Tier 1 Spec $100 copay non Tier 1 Spec		Deductible Then copay applies $70 copay Tier 1 Spec $100 copay non Tier 1 Spec	
Urgent Care	$150 copay		Deductible Then $150 copay	
Emergency Room	Deductible Then Coinsurance		Deductible Then Coinsurance	
Inpatient Hospital Services	Deductible Then Coinsurance		Deductible Then Coinsurance	
Outpatient Hospital Services	Deductible Then Coinsurance		Deductible Then Coinsurance	
1-31 Day Supply Retail Prescription Drugs 32-90 Day Supply Mail Order is 2.5x Retail	Copay: Generic $10 / Preferred Brand $35 Non-Preferred Brand $50		Deductible Then Copay: Generic $10 / Preferred Brand $35 Non-Preferred Brand $50	
Prescription Drugs at the WEHWC Clinic or via clinic mail order	No separate charge		No separate charge	

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.

YOUR PHARMACY INSURANCE

TrueRx



Daniel W., Pharmacist
True Rx Health Strategists

The true**Difference**:

You're more than a number. At True Rx Health Strategists, you become our patient. Our motivation is your health and qualify of life.

Smart medication choices made by ethical health care providers. Our formularies are designed to keep you healthy and productive.

Affordable specialty. If you take specialty medication, your dedicated case manager will reach out and share potential savings for your medication.

Our mobile app lets you compare your medication price at different pharmacies and access your medication history.

Key Steps:

1. https://truerx.com/members
2. DOWNLOAD **true**RX App

trueRX
HEALTH STRATEGISTS

We are here to answer any additional questions. Reach out to us at hello@truerx.com or 866-921-4047.

What pharmacies are in-network?

Please note that CVS pharmacies remain excluded. The TrueRx standard network includes over 65,000 pharmacies nationwide. Please visit www.truerx.com/members and scroll down the page to click the link to check the list of pharmacies.

How do I receive mail order service?

To contact WB Express, please call 812-642-1044 or toll free via 833-391-0126. Online visit: https://wbrxexpress.com/

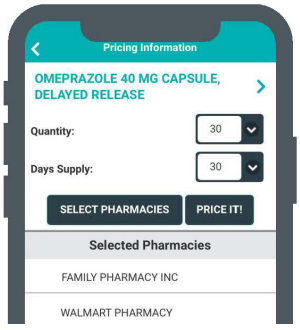
Is True RX Health Strategists a pharmacy?

No, we're not a pharmacy. We're your pharmacy insurance provider. You will continue to receive medications at your local pharmacy while we work in the background to make sure you're getting prescriptions with ease and accuracy.

How much will my medication costs?

You can find the cost of your medication on the trueRx app and compare prices at different pharmacies in your area. You will also see your deductible and other specific information based on your insurance plan.

Drug Name	Costco	Walgreens	Metro Market	Walmart
Alburterol HFA 90 MCG Inhaler	$36.78	$52.71	$36.88	$53.06
Amlodipine Besylate 5 MG Tablet	$0.84	$8.87	$0.94	$9.90
Levothyroxine 50 MCG Tablet	$106.96	$107.46	$107.06	$107.81
Metoprolol Succ ER 25 MG Tablet	$3.32	$7.48	$3.42	$16.43
Metformin HCL ER 500 MG Tablet	$1.62	$5.26	$1.72	$5.25



What should I do if my claim is denied or delayed?

The first thing you should do is take your new insurance card to the pharmacy to make sure they have your new insurance information. If you're still having difficulties, please gives us a call. Our customer service representatives are experts in your pharmacy benefits plan.

SHARx Program

What is SHARx? (pronounced "Sharks")

SHARx is a pharmacy advocacy solution. This program was created to extend advocacy program benefits to employees like you. Our role is to help facilitate the advocacy onboarding process for each eligible member of your employer's health plan and provide access for all high cost medications.

Who is Eligible?

Waukesha County is making this program available to members enrolled in the health plan. If you are currently on any high cost prescription medication, you will want to follow the steps below for potential cost savings to you! If you are eligible to participate in the SHARx program to lowering drug costs for you and your family, follow the instructions in the welcome email or call 314-451-3555.

What is considered a High-Cost Prescription?

Any medication that has a cost of at least $350 per month is considered high cost.

What happens if I don't enroll in the SHARx program?

High cost medications will no longer be covered by the pharmacy benefit plan. Without SHARx, you will be required to pay the full price of the medication. If you are in the advocacy process with SHARx, you may be eligible for a short supply of your urgent medications at your local pharmacy while the advocacy is in process. Certain manufacturers will require additional information to verify your income. Please respond right away to these requests for additional information to ensure there is no delay with your advocacy. Our goal is for everyone to receive the medications they need as quick as possible at the lowest price, and this is only accomplished with your help.

What can I Expect?

It is important to note that this is not an overnight solution and usually takes from two to four weeks on average to implement your cost savings, depending on outside circumstances of doctor cooperation, ease of communication and understanding. You may also be asked to verify your income, so please respond right away. Be patient with this process and realize that SHARx advocates want to help you.

If I am currently enrolled in the SHARx program, what do I need to do come January 1st?

Anyone currently working with SHARx will simply continue to do so. Some members may need to submit updated income documents if they are in a patient assistance free program (depending on when the manufacturers re-enrollment date is). For those that will need to provide any kind of updated information, SHARx will initiate the outreach two months in advance of the patient assistance free program reenrollment date.

SHARx Prescription Assistance

How does it work?

Members will provide SHARx with a HIPAA authorization. This will allow the SHARx advocate to speak with your doctor and the manufacturer of your specialty drug(s) to gather necessary information and apply for discounted programs for you.

Financial information is required to apply for patient assistance programs and will not be discussed with anyone outside of the manufacturer.

The first step will be to look at patient assistance programs available through a drug manufacturer. This first step is income eligibility dependent, and the member would get their medication at no cost through a patient assistance program.

If the patient assistance program is not available due to income eligibility limits or other reasons, the second possible option would be to seek copay cards available through a drug manufacturer. The copay card could result in no cost or significantly reduced costs to the member. Copay card programs are not income dependent. This option may require a participant to first meet the IRS minimum deductible before the copay card covers the cost of the medication. This is to comply with IRS regulations regarding Health Savings Accounts and High Deductible Health Plans.

If the copay card is not available or once the copay card balance is exhausted, the final option would be international mail order for prescriptions. International mail order is not income dependent.

Members who received medications through international mail order are not charged and will receive that medication for free. Medications received through international mail order will be sourced from a U.S. Food & Drug Administration Tier 1 approved Country.

Members would go through the complete process once per year or when an eligible medication has been prescribed to the member for the first time.

Instructions to Create Your Advocacy Request

During onboarding, you have been identified as having a high cost drug, you will receive a welcome email from SHARx. After receiving the email, please follow the instructions in the email:

1. Click on the custom link in the email to create an account on the SHARx platform.
2. Validate your identity and set up a user account for the website.
3. After logging in, you can verify the prescription information we have on file for you and your dependents.
4. Complete a “Request for Advocacy” and we’ll work on saving money for you and Waukesha County.

If you do not receive a welcome email or are prescribed a high cost medicine in the future, please email sharx@sharxplan.com or call 314-451-3555 option 1.

Premium Cost Sharing & Rates

For the 2024 plan year, plan costs are increasing by 2.5% for both plans.

Wellness Premium Differential for Health Risk Assessment Participants

For those members that engage in the Health Risk Assessment, biometric screen, and coaching review for 3+ risk factors, you will pay the lower premium on the Choice Plus plan. There is no premium differential for the HDHP, however you will receive dollars into your Health Savings Account for completing those wellness activities.

SINGLE PLAN	Choice Plus		HDHP High Deductible Health Plan
2024 Cost Sharing	Employee Pays 25% Completed HRA Program*	Employee Pays 50% Did Not Complete HRA Program*	Employee pays 25%
Monthly Premium	$936.39	$936.39	$705.81
County Monthly Share	$702.29	$468.20	$529.36
Employee Monthly Share	$234.10	$468.20	$176.45
Pay Period Deduction Amount	**$117.05**	**$234.10**	**$88.23**

*Health Risk Assessment Program – Health Survey, Biometric Screen, and Health Coach Review for 3+ risk factors.

FAMILY PLAN	Choice Plus		HDHP High Deductible Health Plan
2024 Cost Sharing	Employee Pays 50% 2 HRAs* Completed	Employee Pays 75% 0 HRAs* Completed	Employee pays 50%
Monthly Premium	$2526.34	$2526.34	$1907.18
County Monthly Share	$1263.17	$631.58	$953.59
Employee Monthly Share	$1263.17	$1894.75	$953.59
Pay Period Deduction Amount	**$631.58**	**$947.38**	**$476.79**

*Health Risk Assessment Program – Health Survey, Biometric Screen, and Health Coach Review for 3+ risk factors.

Health Savings Accounts (HSA)

A Health Savings Account (HSA) is like a 457 for healthcare. It is a tax-advantaged personal savings or investment account that individuals can use to save and pay for qualified healthcare expenses, now or in the future. Paired with a qualified high deductible health plan (HDHP), an HSA is a powerful financial tool that empowers consumers.

The dollars roll over from year to year. If the dollars are not used for health care, they can be used in retirement for non-medical expenses and taxed like a 457.

However, unlike other financial savings vehicles (Roth IRA, Traditional IRA, 457, etc.), an HSA has the unique potential to offer triple tax savings through:

- Pre-tax or tax deductible contributions to the HSA
- Tax-free interest or investment earnings
- Tax-free distributions, when used for qualified medical expenses

How is my HSA Funded?

The County contribution is provided once per month and is contributed to employee HSA accounts on the second pay date of each month.

You have the option to contribute additional money into your Health Savings Account (HSA) through the convenience of payroll deductions. Your contributions are made on a pre-tax basis and are not subject to federal or state income taxes, nor social security (FICA) taxes as long as you do not exceed the annual IRS contribution limit. Deductions will be taken from every pay period.

HSA Employer Contribution Amounts

	Single	Family
0 HRAs Completed	$0	$0
Employee or Spouse Complete 1 HRA	**$93.75 per month**	**$125 per month**
Employee and Spouse Complete 2 HRAs	N/A	**$187.50 per month**

Who is eligible to contribute to an HSA?

- You are not covered by any other non-high deductible health plan, such as a spouse's plan, that provides any benefits covered by the County's high deductible health plan.
- You are not enrolled in Medicare or TRICARE.
- You have not received Veterans Administration (VA) benefits within the past three months. Veterans enrolled in a high deductible health plan and who have a service-related disability only may make or receive an HSA contribution regardless of when they received VA benefits.
- You cannot be claimed as a dependent on another person's tax return.
- You are not covered by a health care flexible spending account (FSA) or health reimbursement account (HRA).
- If you are not eligible to contribute to an HSA, you still may be able to contribute pretax dollars to the Flexible Spending Account. More information provided later in the guidebook.

If you are not eligible to contribute to an HSA or your circumstances change and you are no longer eligible, you are responsible for notifying Human Resources. If you have questions about your own situation, please consult a tax or legal professional.

A change in eligibility is not a qualifying event to change health plans. If you enroll in the High Deductible Health Plan, Waukesha County will assume you are eligible to receive the annual employer contribution unless notified not to make the contribution. However, once you are no longer eligible to contribute to the HSA, you can keep the account as long as you like and use it to pay for qualified medical expenses income-tax-free.

PRO Tip: Did you know that if you had a qualified medical expense in the 2023 plan year while on the County HDHP plan, had an HSA account established, but didn't use your HSA to pay for it, you can still go back and reimburse yourself for those expenses?

How much can I contribute to my HSA?

Your total HSA contributions cannot exceed the IRS Contribution Limits (based on a calendar year) shown.

If you are age 55 or older, you are allowed to contribute an additional $1,000 per year on top of the contribution limit. If your spouse is also 55 or older, they are also eligible to make a catch up contribution; however, it must be to an HSA in their name.

Completed HRA Program (Health Survey, Biometrics, & Health Coach Review*)				
	Waukesha County contribution	Employee maximum contribution	2024 maximum contribution	Age 55 Catch-up contribution
Single Coverage	$1,125	$3,025	$4,150	Additional $1,000
Family Coverage	$2,250	$6,050	$8,300	Additional $1,000
*Health Coach Review for those with 3+ risk factors only.				

Partial HRA Completion (Health Survey, Biometrics, & Health Coach Review*)				
	Waukesha County contribution	Employee maximum contribution	2024 maximum contribution	Age 55 Catch-up contribution
Single Coverage	NA	NA	NA	NA
Family Coverage	$1,500	$6,800	$8,300	Additional $1,000
*Health Coach Review for those with 3+ risk factors only				

Did not Complete the HRA Program (Health Survey, Biometrics, & Health Coach Review*)				
	Waukesha County contribution	Employee maximum contribution	2024 maximum contribution	Age 55 Catch-up contribution
Single Coverage	$0	$4,150	$4,150	Additional $1,000
Family Coverage	$0	$8,300	$8,300	Additional $1,000
*Health Coach Review for those with 3+ risk factors only				

What Can I Use the HSA Dollars for?

- All expenses covered under your health, prescription drug, dental or vision plans
- Deductible Expenses
- Coinsurance Expenses
- Dental and Vision out of pockets
- Out of Network benefits
- COBRA Premiums
- Chiropractor
- Acupuncture
- Braces
- Homeopathic
- Psychiatrist/Psychologist
- Lodging when away from home for medical treatment
- Vitamins (with prescription)

Waukesha 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: https://www.wehwc.com/
Facebook: @WaukeshaEmployeeHealthandWellness

Hours

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

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

2024 Costs

Choice Plus Plan:	$0 (includes Preventative, Non-Preventative, & Physical Therapy).
HDHP Plan:	$0 (Preventative); $28.00 (Non-Preventative); $28.00 (Physical Therapy). After the deductible is met, then office visit copay is $0.
HERO Plan:	$0 (Preventative) ; $28.00 (Non-Preventative); $28.00 (Physical Therapy)
Medication:	No separate charge

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.

$28	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.

MH IMAGING

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

The Power of Pretax

Did you know that simply by adding dollars into your Health Savings Account through your paycheck and paying for your Medical, Dental and Vision expenses from the account, you can save meaningful dollars?

Did you also know that even if you don't have dollars in your HSA account at the time of an expense, you can always reimburse yourself from the account as long as you have the receipt?

	Without HSA	With HSA
Income set aside for family health expenses (before tax)	$4,000	$4,000
Minus 25% federal income tax	$1,000	$0
Money left to pay for family health expenses	$3,000	$4,000

Difference $1,000

Low Cost Prescription Drugs

Did you know that the Health and Wellness Center has certain prescriptions available? For a full list of these prescriptions, please see the Wellness Center website on page 16.

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. You may also elect to utilize mail order services through the clinic with SavRx. 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 (if not utilizing clinic mail order). 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.

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.

Choose smart.
Look for blue hearts.

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 a lower copay or receive a higher coinsurance benefit. Members that choose to use in-network providers that are not considered Tier 1 when available will pay a higher copay or receive a lower coinsurance benefit.

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.

FREE!

Real people.
Real Appeal.

Everything you need to lose weight and keep it off — FREE to eligible UnitedHealthcare® members.*

Join today at success.realappeal.com.

Dave L.
Age 47

"I'm stronger. I have a lot more energy. Thank you, Real Appeal."

Tashawna O.
Age 37

"This is no diet — this is not a gimmick. I feel great!"

Real Appeal®

UnitedHealthcare®

Ways to Engage in Your Health Care

Cancer Support Program

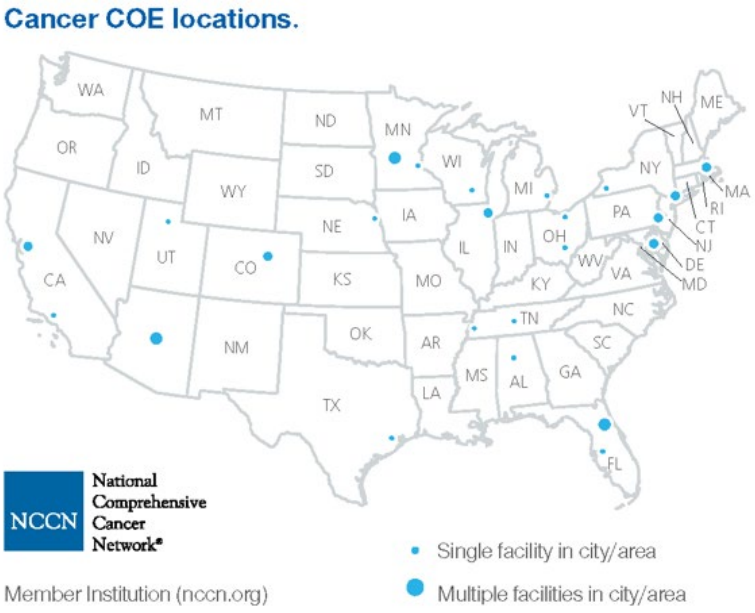
If you are diagnosed with cancer, our partnership with UnitedHealthcare and The Cancer Support Program (CSP) offers you a source of information and guidance navigating the health care system.

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

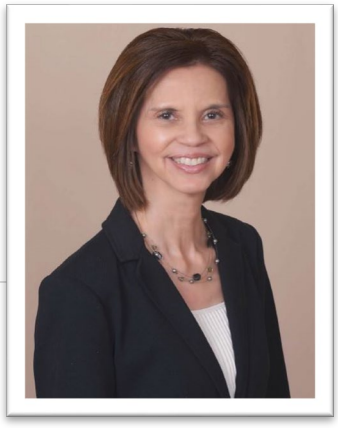
UnitedHealthcare identifies top-quality cancer centers across the country to participate in the Cancer Centers of Excellence (COE) network. These centers provide high-quality, appropriate and cost-effective care, and are reviewed annually to ensure they continue to meet the high standards for which they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

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.

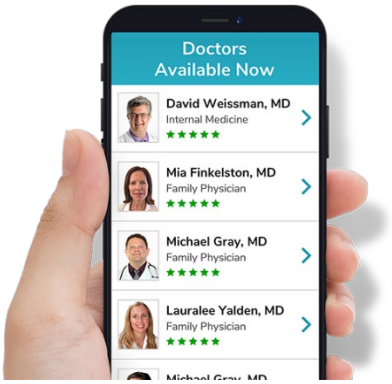
Find Care and Cost

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 (Through UnitedHealthcare App)

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. Log in to your UnitedHealthcare app and a virtual visit. After registering and requesting a visit you will pay your portion of the service costs ($10 for Choice Plus) and (for HDHP $10 after deductible otherwise approximately $50 prior to deductible being met), and then you will enter a virtual waiting room. Telehealth visits with a community provider (e.g. ProHealth, Froedtert, Children's, etc.) do not qualify as virtual visits and will be processed based on the CPT codes billed and the cost share will align with the plan's physician office visits fee structure.

Partnership with Curally

We are excited to announce that Waukesha County has partnered with Curally to support you and your family members whose lives are impacted by major health issues and long-term chronic conditions like Diabetes, Hypertension, Respiratory, Gastrointestinal and Cardiac Disease.

The Curally model involves ongoing face to face management with a highly skilled nurse and a physician Medical Director. Dedicated Curally staff for Waukesha County include Ernie Vesta, MD and Norma Mercado, RN.

If you agree to participate in the program, Curally will coordinate with your existing providers and develop a care plan that is designed specifically for you.

The Curally program is voluntary and is provided at no cost to you. Additionally, Curally takes every step necessary to ensure complete confidentiality.

We will be sharing more information in the coming weeks and months to give you a comprehensive understanding of how Curally could be of substantial benefit to you and your family.

Find out more my visiting this link or scanning the attached QR Code https://curally.com/waukesha/

High Deductible Health Plan Detail

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
1. **Lifetime Maximum**	Unlimited	Unlimited
2. **Annual Deductible (includes full cost Rx)**	$2,100 single/$4,200 family	$4,200 single/$8,400 family
3. **Coinsurance***	80%/20% after deductible 70%/30% after deductible Tier 1 Provider Available but not used	60%/40% after deductible
4. **Out-of-Pocket Expense (includes Rx & office visit copays)**	$1,150 single/$2,300 family	$5,800 single/$11,600 family
5. **Total Out-of-Pocket Maximum (deductible + co-insurance/copay +Rx)**	$3,250/single/$6,500 family	$10,000 single/$20,000 family
6. **Preventive Care**	100% for approved services	60%/40% of eligible expenses
7. **Retail Supply Prescription Drugs**	Copay applies after deductible satisfied Generic $10 / Preferred Brand $35 Non-Preferred Brand $50	NOT COVERED
8. **Hospitalization**	80%/20% of eligible expenses*	60%/40% of eligible expenses
9. **Surgical – Medical Care**	80%/20% of eligible expenses*	60%/40% of eligible expenses
10. **Physician Visits in Hospital**	80%/20% of eligible expenses*	60%/40% of eligible expenses
11. **Maternity**	80%/20% of eligible expenses*	60%/40% of eligible expenses
12. **X-Ray and Lab Tests**	80%/20% of eligible expenses*	60%/40% of eligible expenses
13. **Radiation Therapy**	80%/20% of eligible expenses*	60%/40% of eligible expenses
14. **Emergency Care**	80%/20% of eligible expenses*	80%/20% of eligible expenses, if authorized
15. **Physician Office Exam** All services other than office exam	See Page 4 for copay after deductible 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/per calendar year)	60%/40% of eligible expenses (Maximum of 60 days/per 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 per disability*	60%/40% of eligible expenses, 30 days per 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. Limitations apply*	60%/40% of eligible expenses for approved services. 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**	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

Choice Plus Health Plan (Eligible Employees: Non-Represented hired prior to 1/1/2017)

	Benefits	In-Network	Out-of-Network
1.	**Lifetime Maximum**	Unlimited	Unlimited
2.	**Annual Deductible (Does not include Rx copay)**	$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.	**Out-of-Pocket Expense (Doesn't include Rx copay but does include Office Visit copay)**	$1,800 single / $4,200 family	$8,400 single / $15,200 family
5.	**Total Out-of-Pocket Maximum (deductible + co-insurance +Rx copay)**	$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.	**Retail Supply Prescription Drugs**	Generic $10 / Preferred Brand $35 Non-Preferred Brand $50	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 Exam** All services other than office exam	See Page 4 for copay fees 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**	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.

Supportive Voluntary Worksite Benefits

Supportive Voluntary Benefit Options are offered through The Standard for your Personal Financial Protection include:

- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

New voluntary supportive health plans are available as of January 1, 2024 to help pay for unexpected medical costs and other expenses.

Here's what they do:

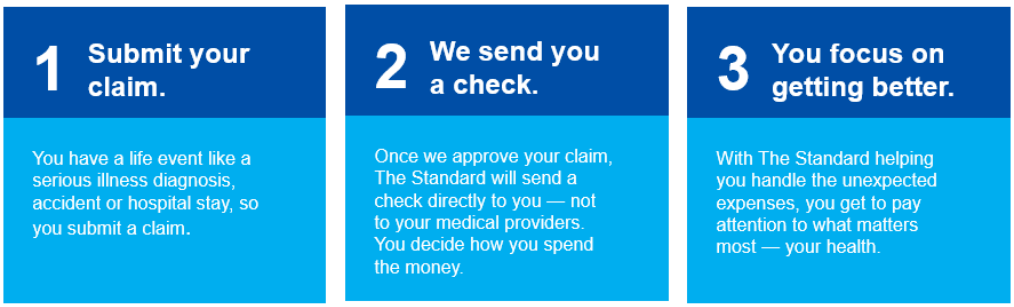
- **Pay you directly**, so you can choose how to spend the money
- **Pay you for what happens**, regardless of your other coverage
- **You can take it with you** if you leave your employment
- **Guaranteed coverage** without any medical questions

Each supportive benefit offering are ala carte, meaning you can select the plans that are right for you and your family. All plans have the option to include your spouse and dependent children if you wish.

Accident Coverage	Critical Illness	Hospital Indemnity
• Off the job coverage • Pays benefits directly to you when an accidental injury happens, and medical attention is needed • Covers many types of injuries, from simple ones like lacerations needing stitches, to complex injuries from serious accidents that require hospitalization • Pays extra benefits if kids are injured in an organized sporting event, like school or club sports • Includes life insurance covering an accidental death • $50 Annual Health Maintenance Screening benefit for EACH covered family member	• Pays benefits directly to you to help with unexpected expenses or lost income resulting from the diagnosis of a covered Critical Illness; the diagnosis must occur while you are covered under the group policy. • You choose a lump sum benefit of $10,000, $20,000 or $30,000 • Automatically covers your children with no extra charge • Covered illnesses include: Heart Attack, Stroke, Cancer, Major Organ Failure, Coma, Paralysis, MS, ALS, Parkinson's, Alzheimer's and more • Specified Childhood Illnesses also included • $50 Annual Health Maintenance Screening Benefit for EACH covered family member	• Pays benefits directly to you to spend as needed, when you or a covered family member is hospitalized • Pays a benefit of $1000 upon admission, plus daily benefits for injuries or illnesses, and includes hospitalization due to pregnancy and childbirth • No pre-existing condition limitation! • Premium waived if you're hospitalized more than 30 days • $50 Annual Health Maintenance Screening Benefit for EACH covered family member

How These Benefits Work

Help Keep Your Finances on Track When a Health Event Happens



Monthly Voluntary Supportive Benefit Premiums

Monthly payroll deductions for Voluntary Supportive Benefits are only offered as an AFTER-TAX deduction, so that any benefits received under these plans are TAX FREE. Employee supportive benefit premiums are deducted only once per month.

	Accident Coverage	Critical Illness	Hospital Indemnity
Employee	$8.10	See below	$13.98
Employee and Spouse	$12.93	See below	$23.91
Employee +Child(ren)	$15.29	See below	$19.92
Employee + Family	$23.96	See below	$35.34

Critical Illness Coverage

Premiums vary by amount of benefit chosen and age of Employee. **If Spousal coverage is chosen also, the rates and benefit amount match the Employee's rate.** The rates are set up in 10-year age brackets.

Employee Monthly Attained Age Premiums						
Coverage Amount	Employee Age					
	18-29	30-39	40-49	50-59	60-69	70+
$10,000	$3.50	$5.20	$10.80	$22.30	$41.30	$72.70
$20,000	$7.00	$10.40	$21.60	$44.60	$82.60	$145.40
$30,000	$10.50	$15.60	$32.40	$66.90	$123.90	$218.10

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 7%.

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.

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.

For all new hires whose dental insurance has not taken effect, your selection made during open enrollment will take effect the later of completing your waiting period or January 1.

www.deltadentalwi.com

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	$68.66	$212.65
County Contribution	$14.90	$51.81	$14.90	$51.81
Employee Monthly Contribution	$14.90	$51.81	$53.76	$160.84
Pay Period Deduction Amount	**$7.45**	**$25.90**	**$26.88**	**$80.42**

If you make a plan change for January 1, 2024, you will receive a new dental insurance card. If you do not receive a new card, please call the HR Office to request one or you can print one directly from your member online account or look it up on app. Don't have an online account yet? Go to deltadentalwi.com to register now.

Maximize Your Benefits

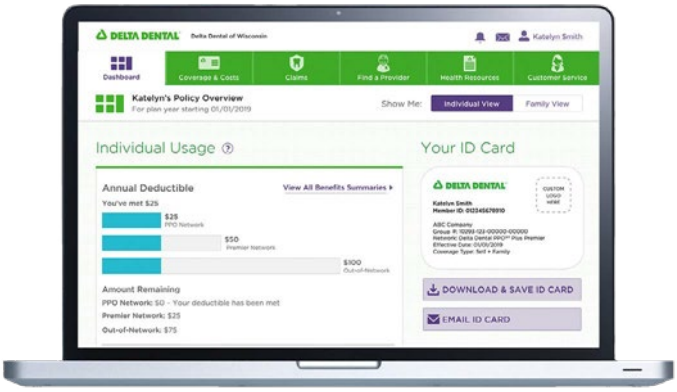
Register for an online account.

Benefits work best when you use them. And we want to make understanding your dental benefits easy. Delta Dental of Wisconsin's online member portal lets you review your benefits or message with a customer experience specialist when it is convenient for you. The more you know, the better your oral health can be.

Logging In
Getting started is quick and easy. Just go to www.deltadentalwi.com and click on "Register" found in the top right corner (on a desktop) or from the menu (on a mobile device). A few simple steps and you'll be able to sign in any time you need to access your dental benefit information. You will need your member ID number (on your ID card) to get registered.

Benefit Dashboard
Once logged in, the dental dashboard allows you to see the most-requested benefit information first— benefit usage, deductibles and annual maximums, plan features, and more—at a quick glance.

Online ID Card
You might not think you need to download a dental insurance ID card at four in the morning ... until you do. You can download it, print it, or email it to a family member or your provider office.



Secure Chat and Messaging
Don't feel like making a phone call? During regular business hours (Monday - Friday, 7:30 am - 5:00 pm), you can securely chat with a customer experience specialist in real time for immediate answers to your benefit questions. You can also send a secure message at your convenience and expect a timely response.

Find a Provider
The online provider search tool can help you find a network dentist in your area. Search by location, specialty, office hours, and other filtering options.

Cost Estimator Tool
Get an estimate for what procedures cost in your area, or from your preferred provider, so you'll have an idea of what you may pay out-of-pocket for necessary dental procedures.

Personalized Content
Manage your communication preferences by selecting topics you are interested in for access to articles and content that will help you make the most of your dental benefits and help you protect your oral health.

www.deltadentalwi.com

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/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.

Vision Coverage

Vision insurance is with National Vision Administrators (NVA).

Premium Cost Sharing

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

Superior Vision	Single	Employee +1	Family
Total Monthly Premium	$7.96	$13.52	$20.48
County Contribution	$3.98	$6.76	$10.24
Employee Contribution	$3.98	$6.76	$10.24
Pay Period Deduction Amount	$1.99	$3.38	$5.12

See next page for schedule of benefits

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Waukesha County
Effective 01/01/2023
Group Number# 3313

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Calendar Year	▪ Covered 100%	Reimbursed Amount ▪ Up to $35
Lenses Once Every Calendar Year	Standard Glass or Plastic	
▪ Single Vision	▪ Covered 100%	▪ Up to $25
▪ Bifocal		▪ Up to $40
▪ Trifocal		▪ Up to $45
▪ Lenticular		▪ Up to $80
▪ Polycarbonates	▪ Covered 100%	▪ Up to $25
▪ Progressive – Tier 1	▪ Covered 100%	▪ Up to $50
Frame Once Every Two Calendar Years	Retail Allowance ▪ Up to $180 (20% discount off balance)*	▪ Up to $75
Contact Lenses Once Every Calendar Year	In lieu of Lenses	In lieu of Lenses
Elective Contact Lenses	▪ Up to $180 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $150
Fit/Follow-Up***		
Standard Daily Wear	▪ Covered 100% after $20 copay	▪ Up to $20
Standard Extended Wear	▪ Covered 100% after $30 copay	▪ Up to $30
Specialty Wear	▪ Covered 100% after $50 copay	▪ Up to $50
Medically Necessary****	▪ Covered 100%	▪ Up to $150
Lasik*** Once per Lieftime	▪ Up to $200	▪ Up to $200

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every calendar year and a frame once every two calendar years or contact lenses and contact lens evaluation/fitting once every calendar year.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 3313000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club or Lenscrafters locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, Lenscrafters, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. ***Only covered if you choose Contact Lenses. ****Pre-approval from NVA required. *****Member is not eligible for lenses & frames.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $12 Ultraviolet Coating
- $10 Solid Tint
- $10 Scratch-Resistant Coating (Standard
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $40 AR Coating – Tier 1
- $50 AR Coating – Tier 2
- $65 AR Coating – Tier 3
- $80 AR Coating – Tier 4
- 20% discount AR Coating – Tier 5
- $39 Retinal Screening
- $80 Progressive – Tier 2
- $100 Progressive – Tier 3
- $120 Progressive – Tier 4
- $140 Progressive – Tier 5
- $165 Progressive – Tier 6
- $190 Progressive – Tier 7
- 20% discount Progressive – Tier 8

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	**Participating Provider**	**Lens Options**
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses $75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard $15 Standard Scratch Coating $12 UV Coating $35 Polycarbonate $45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	$35.00	
Bifocal	$55.00	
Trifocal or Lenticular	$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

Voluntary Term Life Insurance

Employer Paid Life Benefit

The County provides full-time employees with a term life insurance benefit that is based on your salary. There is no cost to employees for that basic life insurance benefit because the County pays this premium.

Employee Paid Life Benefit

We recognize that employees may want to have access to and purchase additional term life insurance as part of their overall financial plan.

If you are currently enrolled in this benefit, you may make a change in your coverage (increase or decrease) once per year during the annual enrollment period without medical underwriting. If you are not currently enrolled and are a late enrollment, you will be subject medical underwriting prior to coverage taking effect.

For all new hires whose life insurance has not taken effect, your life insurance selection made during open enrollment will take effect the 1st of the month following six (6) months from date of hire which may not be January 1, 2024.

Premiums are deducted from the first paycheck of the month.

2024 Voluntary Supplemental Term Life Insurance Monthly Premiums

Age	***Rate per 1,000***	***$25,000***	***$50,000***	***$75,000***	***$100,000***	***$125,000***	***$150,000***	***$175,000***	***$200,000***
20-29	$0.07	$1.75	$3.50	$5.25	$7.00	$8.75	$10.50	$12.25	$14.00
30-34	$0.09	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00
35-39	$0.12	$3.00	$6.00	$9.00	$12.00	$15.00	$18.00	$21.00	$24.00
40-44	$0.16	$4.00	$8.00	$12.00	$16.00	$20.00	$24.00	$28.00	$32.00
45-49	$0.24	$6.00	$12.00	$18.00	$24.00	$30.00	$36.00	$42.00	$48.00
50-54	$0.41	$10.25	$20.50	$30.75	$41.00	$51.25	$61.50	$71.75	$82.00
55-59	$0.68	$17.00	$34.00	$51.00	$68.00	$85.00	$102.00	$119.00	$136.00
60-64	$1.05	$26.25	$52.50	$78.75	$105.00	$131.25	$157.50	$183.75	$210.00
65-69	$2.01	$50.25	$100.50	$150.75	$201.00	$251.25	$301.50	$351.75	$402.00
70+	$3.27	$81.75	$163.50	$245.25	$327.00	$408.75	$490.50	$572.25	$654.00

www.ebcflex.com/

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, copays, certain over-the-counter medications, and other uncovered expenses.
The minimum annual election is $260, and the maximum annual election is $3,050 for 2024 (at time of guidebook publication).

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

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.

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 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, 2024). 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 2024. 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.

If you choose not to enroll and participate in either of these plans for 2024, you will be required to wait until the next annual open enrollment period, unless you experience a qualifying event.

The BESTflex Plan

Dependent Care FSA
Eligible Expenses

What are eligible Dependent Care FSA expenses?

The primary purpose of care must be to provide custodial care while you work, if you are gainfully employed. This means that the care is for the well-being and protection of the dependent. Services include au pairs, nannies, daycare, day camps, babysitters (if care is provided in order for participant to go to work), nursery schools, and preschools.

What expenses are NOT reimbursable?

Examples of expenses that do not qualify for reimbursement are ancillary expenses such as fees for food, art supplies, clothing, field trips, kindergarten, education expenses, child care while on vacation, and overnight camps.

How are Dependent Care expenses reimbursed?

Reimbursements are paid out as funds which are available in your account through your deposits once the dates of service have passed. Therefore, if you submit a claim for the dates of March 1st through March 31st, the claim will not be payable until after March 31st.

If you would like to receive reimbursements sooner, submit claims for shorter time spans. For example, if you've paid for a month of care in advance, you may submit claims for the month by week, and as each week ends, a reimbursement will be processed. You can submit claims for any date span you choose.

Expenses ELIGIBLE for reimbursement in the Dependent Care FSA:
(from the Summary Plan Description)

A. Charges for daycare services outside your home for a "qualifying child" who is under the age of 13 and who depends on you (and your spouse, if you are married) for at least half of his/her support, does not have his/her own dependents, and is not a "qualifying child" of any other taxpayer during the year

B. Charges for care outside of your home for your spouse, dependent adult or child who is mentally or physically incapable of caring for himself or herself and has the same principal place of abode; the spouse or dependent must spend at least 8 hours of each day in your house

C. You may be reimbursed for expenses to provide care to the individual(s) described above in your home if the services are, at least in part, so you (and your spouse, if you are married) may work; the expenses include wages paid to the service provider, but not expenses such as food or clothing

Note: The Dependent Care FSA limits spending to a $5,000 maximum for married and head-of-household filers or $2,500 for those who are married and filing separately

In the case of divorce, separation or parents living apart, special rules apply. In general, the parent with whom the child has spent the most evenings with during the year can claim the benefit

INELIGIBLE expenses for reimbursement:

A. Schooling
(Preschool is generally not schooling)

B. Overnight camps

C. Health care expenses

D Services provided by a person whom you or your spouse could claim as a deduction on your tax return or any of your children who are under age 19

E. Meals, supplies and materials

Employee Benefits Corporation
We make it easy.

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

Online and Mobile Account Features

Participants can file claims, manage Benefits Card transactions, and upload documentation online or using an Android or Apple mobile device.

Employee Assistance Program (EAP)

The EAP is a free benefit provided to all employees and their family members who reside in their household (college students outside of the home also). The EAP is 100% confidential as specified by both state and federal law. There is no cost to the employee or family member for any services provided by the EAP.

Some specialty **work/life services** available through the EAP:

- **Legal Consultation (free 1/2 hour consult per issue)**
- **Eldercare Assessment**
- **Financial Counseling (free ½ hour consult per issue)**
- **Childcare Search**
- **School & College Planning**
- **Adoption Assistance**
- **Mediation (free ½ consult per issue)**
- **Discounted rates on CPAs, Financial Coaches, Attorneys and professional Mediators**

In addition, Advocate Aurora EAP offers face to face, virtual or phone sessions with Masters' level counselors where employees/family members can reach out regarding stress, relationship or family matters, drug or alcohol issues or anything else they desire to discuss. The EAP counselor may then refer to:

- **Additional EAP sessions (up to 8 total per clinical issue)**
- **Insurance based provider**
- **Community Resources**

Please also visit the Advocate Aurora EAP website at www.aah.org/eap.

Call 1-800-236-3231, Monday-Friday, 8:00am to 5:00pm to schedule appointments.

Call 24/7 to talk to an EAP Counselor.

Compliance Notifications

Summary Benefit Comparison and Summary Plan documents are available on the Waukesha County Intranet and the Open Enrollment internet page. If you wish to receive a paper copy, you may call 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).
- Health Savings Account (HSA) Notice to Employees Regarding Employer Contributions to HSAs
- 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.

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.

Open Enrollment Dates: October 2 – 20, 2023

All benefit eligible employees must complete and submit an election form.

Reminder When Submitting Your Election Form:

DO NOT SEND YOUR COMPLETED FORM BACK VIA INTEROFFICE MAIL or from your personal email accounts. These are not secure options, and you are responsible for ensuring the delivery of your documents.

Return your Election Form via the following options:

1. Using your Waukesha County email account, attach and send your completed open enrollment form back to HRBenefits@waukeshacounty.gov.

2. Hand deliver your form to the Human Resources Office in Administration Center Rm 160

Contact Human Resources with questions by calling (262) 548-7044 or be emailing HRBenefits@waukeshacounty.gov