



**MILWAUKEE
PUBLIC SCHOOLS**

2026 RETIREE HEALTH PLANS

Effective January 1, 2026

Open Enrollment is October 20 – November 7, 2025

Application Deadline:

5:00 p.m. Friday, November 7, 2025, with changes effective January 1, 2026

Please retain this booklet for future reference.

Join
Our
Team



MILWAUKEE
PUBLIC SCHOOLS



ATTENTION RETIREES!

Our students need your experience, passion, and leadership. Together, let's *Expect Great Things!*

MPS and MTEA are joining forces to drive our vacancy number to zero! We are looking for retirees interested in returning full-time or part-time or who would consider sharing a classroom with another retiree.

Note: Retirees are encouraged to refer to the Wisconsin Department of Employee Trust Funds information guide on rehired annuitants, which outlines the number of hours they can work so their pension annuity is not affected. MPS staff will work one on one with all prospective applicants.

Now Rehiring!

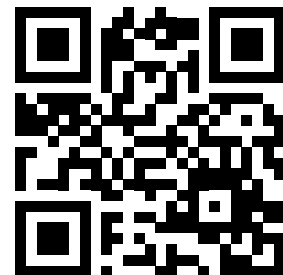
FULL-TIME • PART-TIME POSITIONS

*Scan the QR code
to take a 1-minute
interest survey*



***Together, let's
get to 100%
staffing in
classrooms!***

***We can make a
difference for
MPS students!***



For questions or more information, email mpscoordinators@milwaukee.k12.wi.us or call (414) 475-8224.

Apply for current positions at mpsmke.com/jobs

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Open Enrollment Highlights

Please be sure to take the time to read through the Open Enrollment materials carefully and completely even if you do not change plans.

Non-Medicare retirees (or non-Medicare eligible dependents of Medicare eligible retirees) in the PPO, EPO or High Deductible Health Plan (HDHP)

Consider attending a meeting to learn how to take advantage of your current MPS Medical Plan with UnitedHealthcare. Presented by UnitedHealthcare.

THURSDAY, OCTOBER 30, 2025 11AM – 12PM CT	Click here to join the meeting	Meeting ID: 212 662 297 842 Passcode: nQ9bE2n8
	Download Teams Join on the web	
	Join with a video conferencing device	Tenant key: teams@optum.onpexip.com Video Conference ID: 114 262 940 52
	Or call in (audio only)	+1 952-222-7450,,433296288# United States, Minneapolis Phone Conference ID: 433 296 288#

FRIDAY, October 31, 2025 1 – 2PM CT	Click here to join the meeting	Meeting ID: 211 534 470 559 8 Passcode: xh2tg628
	Download Teams Join on the web	
	Join with a video conferencing device	Tenant key: teams@optum.onpexip.com Video Conference ID: 111 156 048 05
	Or call in (audio only)	+1 952-222-7450,,145073313# United States, Minneapolis Phone Conference ID: 145 073 313#

Virtual Visits: Connect to a doctor by phone or video through <https://myuhc.com>® or the UnitedHealthcare® app. Consider 24/7 Virtual Visits for these common conditions.

	VIRTUAL VISITS		
	Connect to a doctor by phone or video through https://myuhc.com ® or the UnitedHealthcare® app. Consider 24/7 Virtual Visits for these common conditions:	• Allergies • Bronchitis • Eye infections • Flu • Headaches/migraines	• Rashes • Sore throats • Stomachaches • And more!

Will you be age 65 or newly eligible for the MPS Medicare Advantage Plan in 2026?

Documentation with your MBI# must be submitted prior to your effective date for a smooth transition.

This does not apply to retirees and dependents already in the Medicare Advantage plan.

See more information in Non-Medicare retirees section.

Please see Appendix C for 2026 Premium Rates

Medicare Advantage Participants

Attend a meeting to learn how to take advantage of your current UnitedHealthcare Group Medicare Advantage plan. You can join the meeting by phone or online (see information below). Presented by UnitedHealthcare. Both meetings will have the same information.

**Tuesday,
October 28, 2025
10 – 11:30 a.m. CT**

Event address for attendees:
<https://uhc.webex.com/uhc/j.php?MTID=m4743fcc56961b16782497678a8887a55>
Session Password: **MPSEdMtg2025!**
To connect to audio, dial **1-763-957-6400** and enter access code: **2660 671 7458**

**Wednesday,
October 29, 2025
1 – 2:30 p.m. CT**

Event address for attendees:
<https://uhc.webex.com/uhc/j.php?MTID=mc091dccc89c9d7e18b22eaf4f1f7aa4>
Session Password: **MPSEdMtg2025!**
To connect to audio, dial **1-763-957-6400** and enter access code: **2663 018 3002**

To join the online (web) meeting: Select or go to the link above for the meeting date you are joining. Enter the session number. Enter your name and email address. Enter the session password for your meeting. Click “Join Now.” Follow the instructions that appear on your screen. Connect to audio for the presentation by dialing 1-763-957-6400.

To dial-in only for the online meeting:

Call: 1-763-957-6400, TTY 711. Follow the instructions that you hear on the phone.



Renew Active
by UnitedHealthcare

Fitness for body and mind

Renew Active® is the gold standard in Medicare fitness programs for body and mind.
Available with many UnitedHealthcare® Medicare Advantage plans at no additional cost.



Stay fit

Work out where you want, whether that's at a gym or fitness location or from your home.

- A free gym membership
- Access to our nationwide network of gyms and fitness locations. It's the largest of all Medicare fitness programs, including many premium gyms
- An annual personalized fitness plan
- Allows you to bring a family member or friend to the gym with you to assist in your workout, at no additional cost
- Access to thousands of on-demand workout videos and live streaming fitness classes



Stay focused

An online brain health program from AARP® Staying Sharp® with exclusive content for Renew Active members.

- Brain health assessment
- Interactive brain health challenges
- Guide to Music and Brain Health, videos, fun games and more



Stay connected

Connect with other health-minded members.

- Social activities at local health and wellness classes and events
- Step challenges with other members through the online Fitbit® Community for Renew Active — no Fitbit device is needed. Joining the community also provides access to Fitbit Premium™.



Living healthier with Renew

Renew Active is a key part of Renew by UnitedHealthcare®, which offers a wide variety of health and wellness resources and activities to help you take charge of your well-being every day.

Learn more about Renew Active

To learn more about Renew Active today, visit UHCRenewActive.com. Once you become a member of the health plan, sign in to your plan website, go to **Health & Wellness** and look for **Renew Active** to get your confirmation code.

Address Change? Promptly notify MPS and UHC that your address has changed or we may be required to terminate your Medicare Advantage plan coverage. UHC will give you approximately six months before taking action. Notice will be provided to your last known address prior to the termination of coverage. Questions? Call Benefits at (414) 475-8441 or email benefits@milwaukee.k12.wi.us. Submit your address change in writing to:

**Milwaukee Public Schools
Central Services – Payroll Department, Room 120
P.O. Box 2181, Milwaukee, WI 53201**

What Are My Health Plan Options?

Non-Medicare Retirees

Non-Medicare retirees (or non-Medicare eligible dependents of Medicare eligible retirees) can participate in the PPO, EPO or High Deductible Health Plan (HDHP). Appendix A includes a grid summarizing the benefits and costs associated with the plan; Appendix C includes a listing of the monthly premium costs.

What are the differences in Networks between the EPO, PPO and HDHP Plan? Both the HDHP and PPO plan use the UHC Choice Plus Network. This is an expansive network and these plan designs include both an in-network and out-of-network benefit; although there is higher cost-sharing for out-of-network services (generally you will pay 50% coinsurance for out-of-network services). The EPO plan utilizes the UHC Choice network, which has a substantially similar network of doctors to the PPO and HDHP plan; however, the EPO plan provides no coverage for out-of-network services. Under both networks, members have access to local and national providers without the need for a referral.

Reminders for EPO and PPO Plans

Out-of-Pocket Maximum for EPO and PPO

The EPO and PPO Out-Of-Pocket (OOP) maximums include deductible and co-payments. Once you reach your OOP limit, you will have no further cost sharing for covered services. Since your OOP includes deductibles it provides a better benefit by limiting the amount of co-pays that you will pay. Health plans are required to state an Out-Of-Pocket maximum cost for prescription medications. Once you reach your OOP drug limit, you will have no further cost sharing for covered prescription medications. Please note that the Out-Of-Pocket limits for the HDHP plan do operate differently.

Member-Pay-The Difference on Multi-Source Brand Prescriptions

Under the EPO and PPO, and the preventive prescription co-pay in the HDHP plan, there is a feature to encourage use of generic prescriptions. If a brand prescription has a generic equivalent, members will be required to use the generic or pay the difference in cost between obtaining the generic prescription and the brand (i.e. the member will pay the \$8 generic co-pay plus the difference in gross cost between the brand and the generic medication).

Preauthorization Requirement on the EPO, PPO and HDHP Plans

There is an expanded list of services that require preauthorization. In most cases, when you are seeing an in-network provider, your health care professional is responsible for obtaining prior approval. When receiving services out-of-network, you are responsible for contacting UHC for prior approval, or the benefit you receive will be reduced. In the benefit charts in Appendix A, services that require preauthorization are designated by a double asterisk (**).

Compare options, help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to \$2,400 compared to an emergency room (ER) visit.*

Care options to consider	START HERE				
					
	Primary care provider (PCP) The provider who may know you best	24/7 Virtual Visits A care provider over the phone or by video	Convenience care Nurse practitioners and physician assistants at retail pharmacy clinics	Urgent care Physicians and care teams at walk-in clinics	Emergency room Physicians and care teams at hospital emergency departments
Average cost*	In-person: \$170 Virtual: \$99 or less**	Less than \$54***	\$100	\$185	\$2,600
Allergies	✓	✓			
Bladder infection/UTI	✓			✓	✓
Broken bone				✓	✓
Bronchitis	✓	✓		✓	
Chest pain					✓
Cough	✓	✓	✓		
COVID-19 symptoms	✓			✓	
Earache	✓	✓	✓		
Fever	✓	✓	✓		
Flu/common cold	✓	✓	✓		
Migraine/headache	✓	✓			
Muscle ache/sprain	✓		✓		
Pinkeye	✓	✓	✓		
Shortness of breath					✓
Sinus infection	✓	✓	✓		
Skin rash	✓	✓	✓		
Sore throat	✓	✓	✓		
Stomach pain (nausea, vomiting, diarrhea)	✓			✓	
Yeast infection	✓	✓			

✓ Indicates the care option to consider for the common conditions listed above.

To learn more, visit uhc.com/quickcare.

*Source 2021: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated \$2,400 difference between the average emergency room visit, \$2,600 and the average urgent care visit \$185.) The information and estimates provided are for general informational and illustrative purposes only and are not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**Virtual primary care are services available with a provider via video, chat, email, or audio-only where permitted under state law. Virtual primary care services are only available if the provider is licensed in the state that the member is located at the time of the appointment. Virtual primary care is not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Certain prescriptions may not be available, and other restrictions may apply. 24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

***The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.

Check your official health plan documents to see what services and providers are covered by your plan.

OptumRx

Retail pharmacy and home delivery (mail order) coverage with the EPO, PPO, and HDHP remains the same in 2026. There may be tier coverage changes for new-to-therapy medications. The prescription drug list (PDL) coverage information is updated twice per year and can be found on <https://myuhc.com>. To find information about OptumRx home delivery, prescription drug prices, and more: log in to <https://myuhc.com> and select “Manage Your Prescriptions.” Here are some highlights of the home delivery coverage from OptumRx.

Home delivery from OptumRx.

Use OptumRx® home delivery to help manage the medications you take regularly. Home delivery is safe, reliable and offers the following advantages:



Cost savings.

You may pay less for your medication with a 3-month supply through OptumRx.



Convenience.

Get free standard shipping.



24/7 access and reminders.

Speak to a pharmacist any time, any day. Set up medication reminders.

You may be able to refill your home delivery prescriptions automatically through the Automatic Refill program.

If you need your medication right away, ask your doctor for a 1-month prescription to fill at a local pharmacy and a 3-month prescription you can use to set up home delivery.



Choose home delivery.

By going online:

Visit myuhc.com, register and follow the simple step-by-step instructions.

By phone:

Call the member phone number on the back of your plan ID card. It’s helpful to have your plan ID card and medication bottle available.

By ePrescribe:

Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe.*

*This update does not apply to providers in Alaska, Guam, Puerto Rico or the U.S. Virgin Islands.

Making medication decisions.

Use the UnitedHealthcare prescription drug list (PDL).

The PDL is a list of your plan’s covered medications. The medications are organized into cost tiers. Choosing medications in lower tiers may save you money.

Cost tier	Includes	Helpful tips
\$ Tier 1 — Lowest cost	Lower-cost medications. Some brand-name medications.	Tier 1 medications have the lowest out-of-pocket costs. Consider generic alternatives.
\$\$ Tier 2 — Mid-range cost	Mix of brand-name and generic medications.	Tier 2 drugs may cost less than Tier 3 drugs. ³
\$\$\$ Tier 3 — Highest cost	Highest cost brand-name medications and some generic medications.	Many Tier 3 medications have lower-cost options in Tiers 1 or 2. Ask your doctor if they could work for you. ³

Some Connecticut plans have a fourth tier that includes higher cost brand-name and generic medications, as well as non-preferred brand-name and specialty medications.

Save money.

Generic medications usually have a lower co-pay than brand name medications. Ask your doctor if there is a generic alternative for you.

Compare prices.

Search for lower-cost alternatives. Just log in to myuhc.com. Or use the UnitedHealthcare app.

Special Notes on the HDHP Plan

How does the HDHP deductible work? Except for preventive care and preventive prescriptions, all health care (including the costs of prescription medication) are subject to the deductible and coinsurance. This means that the plan will pay 80% of covered in-network costs, after the employee has satisfied the in-network deductible; or 50% of covered costs after the employee has satisfied the out-of-network deductible. Unlike the family deductible within the EPO and PPO (which is, in essence, three separate individual deductibles), the HDHP family coverage deductible is an aggregate total that applies to all individuals covered by the plan. The family coverage deductible must be satisfied prior to receiving any coverage from the plan, even if the entire family coverage deductible is satisfied by one member of the family.

How are preventive medical services covered under the HDHP? Preventive medical care as specified in the health care reform law under the HDHP is covered at 100% and is not subject to either the deductible or coinsurance. There is no cost sharing on these essential preventive office visits.

How are medications covered under the HDHP? Under the HDHP plan, there is a difference between how “preventive” medications and all other medications are covered. Preventive prescription medications are subject to the three-tier co-pay/coinsurance structure. If a covered medication is not on the preventive list, it is subject to the deductible and coinsurance; you will be required to pay the full cost of the medication until your deductible is met and 20% thereafter. You can find a list of preventive medications posted on the MPS Website at <https://mpsmke.com>, click Careers > Retirement & Pensions > Retirement Health Benefits link.

HDHP Out-Of-Pocket Maximum (OOP)

Unlike the other health plans, the HDHP has a combined prescription drug and medical Out-Of-Pocket maximum. All member deductible, coinsurance and co-pays for covered medical expenses and prescription drugs apply toward the Out-Of-Pocket maximum. Once the Out-Of-Pocket limit has been satisfied, there are no additional costs to the member for covered medical and prescription benefits in the calendar year.

If I am a non-Medicare retiree, am I eligible for the HDHP plan? You are able to enroll in the HDHP plan if you choose. However, MPS cannot open a Health Savings Account (HSA) for you and cannot make any contribution toward a HSA account should you choose to set up a HSA. (A Health Savings Account is a member owned bank account that allows members to save money in a tax-advantaged account toward current and future medical expenses and potentially save toward retirement). However, you may open a HSA account at a bank of your choosing if you meet IRS requirements regarding eligibility for HSA accounts. For more information on HSAs please see IRS publications 969 (<http://www.irs.gov/publications/p969/index.html>).

How do I know which plan is best for me? To evaluate which health plan is best for you, you need to be aware of what you currently spend for health care. Start by getting a picture of what you and the health plan spend on your health care by looking at your UHC account (<https://myuhc.com>) and your prescription drug costs, or while logged into your <https://myuhc.com> account login, click on Manage My Prescriptions. Look at both what you and the plan pay toward the cost of care. Take into account the full cost of each plan, including monthly premium costs. Then compare the savings from reduced premiums and evaluate whether the HDHP option might be best for you.

**For Non-Medicare retirees (or non-Medicare eligible dependents of Medicare eligible retirees)
in the PPO, EPO or High Deductible Health Plan (HDHP):**

Real AppealSM

Milwaukee Public Schools is excited to offer Real AppealSM, an online program to spark your weight loss transformation. Meet with an online coach to create health goals, track your activity, and find new ways to keep your body moving. Real AppealSM is a program on Rally CoachTM available to you and eligible family members at no additional cost as part of your medical plan benefits, subject to eligibility requirements.

Everything You Need to Create Healthy Habits

- 🎯 Fitness and nutrition trackers to focus on health goals
- 🎯 Online sessions led by a coach with a supportive community of members
- 🎯 A Success Kit delivered directly to you with food and weight scales, helpful guides, and more





Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.



Get healthier, at no additional cost to you

Real Appeal on Rally CoachTM is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.



Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

Join today at enroll.realappeal.com or scan this code



United Healthcare

Real Appeal

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Services, Inc. or their affiliates. © 2022 UnitedHealthcare Services, Inc. All Rights Reserved. WF8689358 222420A-102022 CHC

Will you be age 65 or newly eligible for the MPS Medicare Advantage Plan in 2026? We need your MBI!



Newly eligible retirees and dependents for the MPS Group Medicare Advantage plan must submit documentation from Medicare that shows their Medicare Beneficiary Identifier (MBI) for enrollment into the Medicare Advantage Plan. **We need this documentation as soon as possible but no later than the month prior to your effective date in order to provide uninterrupted health coverage.** Under MPS' Health insurance plan, you are required to enroll in Medicare Parts A & B upon becoming eligible and pay the Part B premium to Social Security. This means that you have met one of the following requirements:

① Attained the age of 65

Upon attaining age 65, your plan will transition to our MPS Medicare Advantage plan effective the month of your birthday (or the previous month if your birthday is on the 1st of the month) provided you are enrolled in both Medicare Parts A & B. In order to enroll, you MUST provide your new MBI number:

- MBI numbers are unique, randomly assigned numbers now being issued by the federal government to Medicare enrollees.
- This MBI number is needed by MPS to process your enrollment in the MPS Medicare Advantage Plan.
- Please send a copy of either (1) your Medicare ID card indicating your MBI number and effective dates of your Part A and Part B enrollment, or (2) a copy of the Medicare award letter which contains your MBI assigned number in the heading.
- The sooner we receive either document copy the sooner we can process your enrollment and avoid a loss of coverage.

② Offered Medicare Part B due to disability

③ Diagnosed with End-Stage Renal Disease (ESRD)

If you have End Stage Renal Disease (ESRD) information to disclose, please provide the start date of your ESRD entitlement or contact the Social Security Administration for assistance in finding your ESRD entitlement date at 1-800-772-1213.

④ Offered Medicare Part B for any other reason

Upon attaining any item listed above (2-4), your plan will transition to our MPS Medicare Advantage plan the day you are effective for Medicare Parts A & B, provided you are enrolled in both plans and you have notified MPS of your eligibility.

Medicare eligible retirees and dependents are required to enroll in Medicare Parts A & B and pay the Part B premium to Social Security to continue to be covered under the MPS Health insurance plan.

Special Enrollment Information for Medicare Eligible Retirees/Dependents

Do I have the option to not enroll in the MPS Group Medicare Advantage Plan? Before deciding not to join this plan, you need to know that in order to continue to have prescription drug coverage through the Milwaukee Public Schools plan, you must have medical coverage as well. If you choose to decline participation in the MPS Group Medicare Advantage plan, you will be irrevocably waiving participation in the MPS retiree health insurance program now and in the future. If you are already enrolled in the MPS Group Medicare Advantage Plan, you do not need to take any action to remain enrolled in this plan for 2026.

What if I am already enrolled in another Medicare Advantage Plan? Federal regulations only allow you to be enrolled in one Medicare Advantage plan. Unless you opt-out of participation in MPS's Group Medicare Advantage plan, you will be automatically enrolled in the MPS program and automatically dis-enrolled from your prior Medicare Advantage plan. Please keep in mind that if you elect not to participate in the MPS Group Medicare Advantage plan, you will be irrevocably waiving participation in MPS retiree health insurance program both now and in the future. To opt-out or terminate the MPS Group Medicare Advantage plan you must contact MPS Benefits for the appropriate form. Please contact your MPS Benefits Associate below:

LAST NAMES A – F	(414) 475-8158	LAST NAMES G – L	(414) 475-8233	LAST NAMES M – R	(414) 475-8215	LAST NAMES S – Z	(414) 475-8559
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How do I enroll in the plan? In order for your enrollment in the MPS Group Medicare Advantage plan to be confirmed, the Centers of Medicare and Medicaid (CMS) require specific information. Examples of required information include:

- Physical Street address (CMS will not accept a P.O. Box address)
- Medicare ID number
- Part B Enrollment

Please contact MPS if you think your information is not current. If MPS records show that you are currently missing this information, we will contact you shortly to gather the information so your enrollment into the MPS Group Medicare Advantage plan can be processed.

Note: Out of Area/Mail is returned to UnitedHealthcare (UHC). Promptly notify MPS and UHC that your address has changed or we may be required to terminate your Medicare Advantage plan coverage. UHC will give you approximately six months before taking action. Notice will be provided to your last known address prior to the termination of coverage. Questions? Call Benefits at (414) 475-8441 or email benefits@milwaukee.k12.wi.us.

If you turn age 65 and become Medicare eligible during the calendar year, please note that if you do not enroll in Medicare Parts A and B when first eligible, you may be subject to a penalty due to late enrollment in Medicare. Failure to enroll in Medicare Parts A and B will result in a loss of retiree insurance eligibility and your MPS retiree health program will end. For information on how to enroll in Medicare Parts A and B, refer to www.Medicare.gov or call the Social Security office at 1-800-772-1213. Look for information in the mail regarding the MPS Group Medicare Advantage plan from UnitedHealthcare for 2026.

Medicare Eligible Retirees

Currently, all Medicare eligible individuals are automatically enrolled in our MPS Group Medicare Advantage plan, through UnitedHealthcare (UHC). In order for this automatic enrollment to occur, **Medicare eligible individuals must be enrolled in both Medicare Parts A & B.** The MPS Group Medicare Advantage plan is a benefit that is exclusively available to MPS retirees and offers a higher level of benefits than Medicare Advantage plans that are available on the individual market.

This benefit program is a zero-deductible plan with a lower monthly premium cost and includes additional wellness benefits such as the **Renew Active® by UnitedHealthcare**. You can find a summary chart of the benefits under the Medicare Advantage Plan in Appendix B: MPS Group Medicare Advantage Plan Details.

What if one of my family members is not Medicare eligible? If one of your family members is not Medicare eligible, he or she will continue to be enrolled in your current election (EPO, PPO or HDHP), unless you make a different election (i.e. switching to the EPO, PPO or HDHP plan during Open Enrollment).

Do I still need to maintain my Medicare B enrollment? Yes. You are required to maintain your Medicare Parts A and B enrollment while enrolled in the MPS Group Medicare Advantage plan. If you have a Board paid subsidy toward your retiree premium and the cost of this plan is less than your Board subsidy, retirees will continue to receive the standard Medicare Part B premium reimbursement. As always, this Medicare Part B premium reimbursement is available to retirees only and is not available to spouses or surviving spouses of retirees.

Note: You must continue paying your Medicare Part B premium to be eligible for coverage under this plan. If you stop paying Medicare Part B premium, you may be disenrolled from this plan.

If I am a retiree eligible for Part B reimbursement, when can I expect this reimbursement monthly? Eligible monthly Part B reimbursement payments are made with the first payroll of each calendar month. The following chart illustrates the dates in calendar year 2026 when eligible payments will be made. Note that, depending on the payroll date, your payment can reach you earlier in some months and later in other months:

2026 CALENDAR YEAR											
JAN 2	FEB 13	MAR 13	APR 10	MAY 8	JUN 5	JUL 2	AUG 14	SEP 11	OCT 9	NOV 6	DEC 4

MPS no longer issues paper checks or mails payment advices to retirees receiving a Medicare Part B reimbursement. Direct deposit of these payments is now mandatory.

If you already have direct deposit authorization set up for your Medicare Part B reimbursement, no action is required.

If you do not have direct deposit set up or need to change the bank where your direct deposit will go, please contact payroll at Payroll@milwaukee.k12.wi.us for a Direct Deposit form to be sent to you.

If you do not have a bank account, we do have Rapid! PayCards where your money can be loaded. When filling out the direct deposit form, you would check the section that states “Request a Rapid! PayCard.” Payroll will then send you a card to activate.

If you have questions or would like to speak to one of the payroll assistants, email Payroll@milwaukee.k12.wi.us or call (414) 475-8300 during regular business hours, 7:30 a.m. to 5:00 p.m. Central Time. Return your completed Direct Deposit Authorization Form to:

MPS – Attention Payroll
5225 W. Vliet St., Milwaukee, WI, 53208

What happens if I become Medicare eligible during the course of the plan year? If you become Medicare eligible during the plan year, you will be automatically enrolled in the MPS Group Medicare Advantage plan starting with the first day of the first month of your Medicare eligibility. Note: You must be enrolled in Medicare Part A and Part B and provide MPS with your Medicare Beneficiary Identifier (MBI) for this automatic enrollment to occur. Failure to enroll in Part A and Part B and make Part B premium payments to Social Security may result in a lapse in your MPS retiree insurance coverage, or may leave you uninsured.

You will receive pre-enrollment and enrollment materials directly from UHC as you transition to this plan. Note: Your deductible and Out-Of-Pocket maximum amounts will not transfer to the MPS Group Medicare Advantage plan. However, the MPS Group Medicare Advantage plan is a zero-deductible plan.

Can I opt out of participation in this plan? Yes, but if you are Medicare eligible and opt out of participation in the MPS Group Medicare Advantage plan, you are opting out of participation in MPS retiree health insurance program and will be waiving your right to participate in the MPS retiree health insurance program now and in the future. To opt out or terminate the MPS Group Medicare Advantage plan you must contact MPS Benefits for the appropriate form. Please contact your MPS Benefits Associate below:

LAST NAMES A – F	(414) 475-8158	LAST NAMES G – L	(414) 475-8233	LAST NAMES M – R	(414) 475-8215	LAST NAMES S – Z	(414) 475-8559
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How your UnitedHealthcare® Group Medicare Advantage plan works

Medicare has rules about what types of coverage you can add or combine with a group-sponsored Medicare Advantage plan

One plan at a time

- Usually, you may be enrolled in only one Medicare Advantage plan and/or one Medicare Part D prescription drug plan at a time.
- The plan you enroll in last is the plan that Centers for Medicare & Medicaid Services considers to be your final decision.
- If you enroll in another Medicare Advantage or Medicare Part D plan after enrolling in this group-sponsored plan, you may be disenrolled from the group-sponsored plan.
- Any eligible family members may also be disenrolled from their group-sponsored plan. This means that you and your family may not have hospital/medical or drug coverage through your plan sponsor or former employer.



Remember — If you drop or are disenrolled from your group-sponsored retiree coverage, you may not be able to re-enroll. Limitations and restrictions vary by former employer or plan sponsor.



Enrollment Procedures

Am I required to submit an application? Complete the enclosed Open Enrollment (OE) Application if:

- ▶ You wish to change your present health plan,
- ▶ You are changing dependent(s) covered under those plans, if applicable,
- ▶ You are updating/correcting information on the form. OE changes are effective January 1, 2026. **If you do not return an enrollment form, MPS will continue your current eligible coverage.**

Note: If you are already enrolled in the MPS Group Medicare Advantage Plan, you do not need to take any action to remain enrolled in this plan for 2026.

How do I enroll in my chosen plan?

- ❶ Use the enrollment application *enclosed with this booklet*, which contains your individual information.
- ❷ Keep a copy for your records and submit or mail the original form to Milwaukee Public Schools, Office of Human Resources, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Room 124, Milwaukee, Wisconsin 53208 or fax it to (414) 475-8562.

What if my spouse is a MPS retiree? For retirees where both spouses are retired from MPS and meet eligibility requirement for retiree health coverage as of his/her retirement date, the Board only pays its portion of the retiree health premium rate in effect as of his/her date of retirement for (1) family coverage or (2) single plans.

When can I make changes outside of the Open Enrollment Period? After Open Enrollment, additions, terminations, and changes to retiree coverage are limited and will only be allowed to your MPS health plans as the result of an applicable family status change. In order to make changes to your MPS health plans, you must file a new, complete application with MPS Department of Benefits, Pension & Compensation within:

- ▶ 31 calendar days of a qualifying family status change (Divorces, Death, Loss of Coverage only)
- ▶ 60 calendar days for birth, adoption, or loss of Medicaid or State Children's Health Insurance Plan (CHIP).

Remember: You are required to report other insurance changes and allowable retiree family status changes immediately to MPS Department of Benefits, Pension & Compensation throughout the year as they occur. Do not miss these deadlines to report this important information.

What documentation is required to complete an allowable retiree family status change? The following is a list of the most common allowable retiree family status changes and the documentation needed to make a change:

Family Status Change	Copy of Document or Notice Required
Birth	Birth certificate or proof that the birth certificate is registered. Allowed only under a current family plan.
Adoption	Court adoption or adoption agency placement letter; allowed only under a current family plan
Divorce	Notification of date of divorce.
Death	Notification of date of death.
Loss of Other Insurance Coverage	HIPAA notice of coverage loss; allowed only for dependents, not a spouse, under a current family plan
<i>Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation will delay processing of your change. If verification is not received within 31 calendar days of our written request, the change will not be completed and will have to wait until the next Open Enrollment period.</i>	

What if I am a retiree and marry after retirement? What if I have a single retiree plan? Retirees with MPS retiree health coverage cannot add a new spouse to their retiree health plan. If you have family coverage and change to single coverage during retirement, you cannot change back to a family plan. If you retire with single coverage, you cannot change to family coverage.

Open Enrollment Application Instructions

Retirees Only

If you are making a change to your current coverage or updating your coverage information, please complete the 2026 Open Enrollment Benefits Application Form that was included in your Open Enrollment packet. Complete the 2026 Open Enrollment Benefits Application Form by selecting a Health plan option. You may select only one. Please note the following:

- ❶ If you have single coverage, please verify information on the application form for yourself (subscriber).
- ❷ If you have family coverage or want to correct any of the information provided about your dependents, please complete/correct the Dependent(s) section of the application form for all eligible dependents in addition to yourself and your spouse, if applicable. Indicate “yes” if you want to enroll your dependents in health coverage or “no” if you do not want to enroll your dependent(s) in health coverage.

Note: Adding an eligible dependent is allowable only for retirees with current family plan coverage. If deleting a dependent, please provide reason for deletion and event date (see application).

- ❸ Only eligible dependents will be accepted. Refer to the Dependent Eligibility Rules section beginning on page 15 of this booklet for detailed information on eligible dependents. Additional information may be requested to verify a dependent’s eligibility. *Coverage will not be effective for any dependents not included on the application form.*
- ❹ If you are enrolling dependents the following is a list of valid options for the Dependent Relationship section: Natural or Adopted Child, Grandchild (see requirements under Dependent Eligibility Rules), Legal Ward/Guardian (documentation of such status is required if it has not already been provided), and Stepchild.

- ❶ If you have a *disabled dependent*, indicate yes on the application form and whether the dependent is Medicare eligible. Additional information may be requested to verify the disabled status of the dependent.
- ❷ If you are enrolling any dependent(s) you must submit verification of dependent eligibility. Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation can delay or possibly prevent the enrollment of your eligible dependents.
- ❸ If you are making changes or corrections, please retain a copy of the application for your records.
- ❹ If you do not return your form to MPS Department of Benefits, Pension & Compensation in person, please mail the original Open Enrollment Application Form to Milwaukee Public Schools, Office of Human Resources, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Room 124, Milwaukee, WI, 53208 or fax it to: (414) 475-8562.

Terms and Conditions of Submitting Applications

By completing the MPS Open Enrollment Benefit Application form, you are agreeing to the following terms and conditions:

- ❶ I hereby apply for enrollment/plan membership for the person(s) listed and agree that my dependents and I shall abide by the provisions of coverage in the service agreement under which we are enrolled.
- ❷ I understand enrollment is subject to all of the terms and conditions on the Master Group Policyholder Agreement with the provider I have chosen.
- ❸ I hereby authorize deductions from my earnings of the required contributions toward the cost of the monthly premium as required by the terms and conditions of employment.
- ❹ I consent and authorize any physician, dentist, consultant, hospital or other person by whom any diagnosis, medical, surgical, dental treatment or advice has been rendered to release pertinent medical, surgical, dental reports and records as requested to the insurance plan I selected subject to all applicable provisions of the Health Insurance Portability and Accountability Act of 1996.
- ❺ I understand that coverage is effective only upon timely submission of a complete application to MPS.

- 6 I certify that the application information is complete, true, and correct subject to State, Federal and Board policy insurance fraud penalties governing eligibility for and payment of health insurance benefits for myself and my claimed dependent(s). MPS reserves the right to pursue appropriate legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. I have shared the “General Notice of COBRA Continuation Coverage Rights” with all eligible family members. As information requested on this form changes, I understand I must promptly inform MPS Department of Benefits, Pension & Compensation in writing within 31 calendar days of a Qualifying Family Status Change or 60 calendar days for birth/adoption or loss of Medicaid or CHIP. Please refer to *Dependent Eligibility Rules* below for additional details. Failure to provide such written notice may result in loss of coverage or denial of benefits.
- 7 MPS reserves the right to determine eligibility and obtain all necessary information to verify eligibility. MPS also retains the right to conduct periodic audits, including random audits for eligibility verification.

Dependent Eligibility Rules

Retirees Only

Enrolling a dependent(s) to retiree health coverage is limited to a current retiree family plan only and you must submit verification of dependent eligibility. For example, if you are enrolling a dependent child(ren) you must submit a birth certificate(s). Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation may delay or prevent processing of your eligible dependents. Remember, retirees cannot add a spouse to a retiree health plan. As per Board policy and Plan provisions, the following dependents are eligible for coverage:

- **Spouse** is the person to whom the subscriber is legally married.
- **Dependent Child** includes the following:
 - Natural or adopted child of the subscriber.
 - Stepchild - is the natural or adopted child of the subscriber’s spouse for whom the subscriber and/or spouse provide more than 50% of the child’s support during a calendar year.
 - Legal Ward - is a child for whom the subscriber or current spouse is the legal guardian and for whom the subscriber and/or spouse provide more than 50% of the child’s support during a calendar year.
 - Grandchild - is a child of the subscriber’s dependent child for whom the subscriber and/or spouse provide more than 50% of the grandchild’s support during a calendar year when the grandchild’s parent is under age 18.
- **Adult Child Dependent Eligibility** – As a result of State and Federal mandated changes* to health coverage, adult dependent children (age 19 and older) must meet coverage eligibility as outlined below. These mandates do not require you to cover your adult children under your MPS health plan.
 - Adult child is between the ages 19 to 26.
 - Adult child can be single or married.
 - Per State mandate, eligibility requirements also include the adult child who is a full-time student regardless of age and was under age 27 years when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.
 - Application for disabled dependents continuation of health coverage must be completed prior to turning age 26.

*WI Statute 632.885; Federal Acts PPACA and HCERA

Removing Ineligible Dependents from Your MPS Health Plan

You are required to notify the MPS Department of Benefits, Pension & Compensation of events such as a divorce or death of spouse in order to remove ineligible dependents from your plan. In the case of divorce, your ex-spouse and your step-child(ren) from that marriage are no longer eligible to be covered as your dependents and you must remove them from your MPS health plan within 31 calendar days. MPS reserves its right to pursue any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud.

When Health Coverage Ends

Board paid health coverage for the retiree and all dependents ends on the last day of the month in which the retiree becomes ineligible due to non-payment of the required retiree or surviving spouse premium contribution. As per Board policy/procedures, Plan provisions, and State/Federal mandates, coverage ends for dependents as follows:

- ❶ **Spouse** – Coverage ends at the end of the month in which the spouse is no longer legally married to the subscriber.
- ❷ **Dependent Child** – Coverage ends at the end of the month in which adult child attains age 26 per current state and federal mandates in effect as of the date of this publication.
Note: See Adult Child Dependent Eligibility on the previous page for additional details. Health coverage ends at the end of the month in which the child attains age 26, regardless of support, unless prior to attaining age 26 the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the subscriber and/or subscriber's spouse for support and maintenance. Proof of such incapacity and dependency must be furnished by the subscriber to the retiree's health plan, at no expense to the retiree's health plan, within 31 calendar days of the child's attainment of age 26, and subsequently when and as often as the retiree's health plan may reasonably require but not more frequently than annually after the two-year period following the child's attainment of age 26.
- ❸ **Grandchild** – Coverage ends at the end of the month when the grandchild's parent loses dependent status or the grandchild's parent turns 18 or the subscriber and/or spouse no longer provide more than 50% of the grandchild's support.
- ❹ **Loss of Legal Status** – Coverage ends at the end of the month in which the child no longer meets the definition of stepchild or legal ward. For example, a stepchild's parent is no longer legally married to the subscriber; legal ward's coverage ends at age 18.
- ❺ **Emancipation** – Coverage ends at the end of the month in which the child is legally emancipated, even if the emancipation occurs prior to the attainment of age 19.

In the event you, your spouse (through divorce) or your dependent children (reaches age 26) lose Board health insurance coverage, you are then eligible to remain in the group on a self-pay basis for either 18 or 36 months. For more information about COBRA continuation, see section under Mandatory Notices in this booklet.

Frequently Asked Questions

What is a deductible? A deductible is a flat-dollar amount you pay annually, on a calendar year basis, before coinsurance benefits are payable. If you are enrolled in a family EPO or PPO plan, the deductible can be met by one individual at a time or you pay up to three individual deductibles to meet your maximum family deductible for the calendar year. Under the HDHP, the family coverage deductible is an aggregate total that applies to all individuals covered by the plan. See section "How does the HDHP deductible work?" Under the UnitedHealthcare PPO plan and under the HDHP, in-network and out-of-network deductibles ARE NOT cross-applied.

Do I have to pay the deductible up front before my insurance pays anything? In general, when a plan has a deductible and coinsurance, the providers will bill the third party administrator (UnitedHealthcare) first to determine what contractually will be paid under the plan. Then the provider will bill you for the amounts not paid by the administrator, which should be the deductible and coinsurance amounts. Look for your Explanation of Benefits (EOB) statements from UnitedHealthcare to confirm that your calendar year deductible and coinsurance have been applied and they agree with what the provider is billing you.

To whom do I pay the deductible? You pay the deductible or coinsurance under the plans to the provider directly. This may be requested by the provider up-front (at the time the services are rendered) or the provider will bill you for these amounts not payable by the administrator (UnitedHealthcare). Remember, any covered amount applied to your deductible is your responsibility and you will need to pay the appropriate provider.

Do I need to find an in-network hospital when I have an emergency? The Emergency Room (ER) is for treatment of life-threatening or very serious conditions that require immediate medical attention. Your MPS health plan provides an Emergency Room benefit for your care, whether the hospital is in-network or out-of-network.

I don't understand when I should pay the co-pay versus the coinsurance, what is the difference between the two? Co-pays are typically a flat dollar amount (but can be a percentage amount) that you pay each time you use the service and the plan pays the balance for that service. For example, for a hospital emergency room service, the PPO plan pays 100% after you pay the \$150 co-pay. For an in-network, non-surgical specialist office visit, the PPO plan pays 100% after you pay the \$35 co-pay. *Note:* In the case of a physician (non-specialist) visit, which is a flat co-pay of \$20, if you have additional services like lab work (i.e. blood draw), diagnostic or x-ray services, these additional services are subject to the deductible and coinsurance up to your annual limit.

After the deductible is met each year, the plan pays a percentage of most covered expenses and you pay a percentage. This percentage is your coinsurance. Note that the percentage paid by the plan for in-network services is greater than the percentage paid for out-of-network services, giving you an incentive to use in-network providers since your coinsurance will be less. For example, assuming you have satisfied the applicable deductible under the MPS PPO plan, for an in-network \$200 lab charge the plan would pay 80% or \$160 dollars and you would pay a 20% coinsurance of \$40.

How does UnitedHealthcare determine calendar year benefit maximums for a plan year? Calendar year benefit maximums are payment limits applied to specific covered medical services that are incurred during the plan year, which is January 1 through December 31 each year. Once a specific calendar year maximum limit has been reached by a covered member under the plan, no more benefits will be payable by that plan for that particular service for the remainder of the calendar year. These maximums can be stated as day, dollar or visit limits depending on the covered service and are standard under most health care plans including the MPS plans.

Covered services are tracked by each individual member under the same subscriber record for the calendar year, even if the plan type changes at any time during the calendar year. For example, if a member moves from active status to continuation coverage under COBRA, the benefit usage remains with the individual and continues to be applied to the benefit limit for the remainder of that calendar year. For instance, if a member used 14 of the 20 physical therapy visits from January through April of a given year, and then continues under COBRA on May 1, that member would have 6 visits remaining before they reached the benefit maximum for that calendar year.

What if my spouse is also employed by MPS and I want to switch to his/her plan? If you change subscriber records during the calendar year, any deductible, coinsurance and covered services limits met in the calendar year do not transfer with the individual. For example, a spouse-to spouse transfer during the year where the dependents are now covered under another subscriber record will not have deductible, coinsurance and covered services transferred with them. New deductible and coinsurance maximums will need to be met for the remainder of the calendar year for every family member covered under the spouse-to-spouse transfer. *Note:* If you are a retiree and you switch to your spouse's active employee plan, you will not be able to return to your retiree plan at a later date.

Remember, services need to meet all plan provisions including medical necessity – a specific dollar or visit limit stated for a benefit is not a guarantee of coverage up to that limit. UnitedHealthcare regularly reviews claims in accordance with plan provisions prior to benefit limits being met. As always, if in doubt, your healthcare provider can review the plan's coverage limitations including calendar year benefit maximums and pre-authorize such services.

How does electronic coordination of benefits (eCOB) work for pharmacy benefits provided by OptumRx?

If the MPS OptumRx Plan is secondary coverage for prescription drugs because you and any of your covered dependents also have other insurance covering prescription drugs, coordination of benefits is available electronically (eCOB) at retail, in-network OptumRx pharmacies. This means that your prescription drug claims can be submitted easily, automatically and without the claim submission paperwork to OptumRx for secondary payment reimbursement.

To take advantage of eCOB, you must use an in-network pharmacy set up for electronic claims submission. To find out whether your pharmacy can submit electronic claims, just ask the pharmacist. If the pharmacy is equipped for electronic claims submission, simply show both the primary insurance coverage identification card and your MPS Health/OptumRx card. Your claim will be processed electronically on the spot with both plans paying their respective share of your claim. You then pay only your Out-Of-Pocket costs for every prescription at the time of purchase.

Remember that if an OptumRx network pharmacy is not equipped to submit electronic COB claims, you must continue to submit paper claims to OptumRx for reimbursement of your covered Out-Of-Pocket expenses. Also, if your covered dependents' primary plan requires full payment, you must make that payment and submit a paper claim for reimbursement, first to the primary insurance, then to OptumRx. To avoid disruption of coverage using eCOB, remember to update UnitedHealthcare with changes to your other insurance coverage, at any time throughout the year, for you or your covered dependents under a MPS plan. You may contact UnitedHealthcare for the EPO, PPO, or HDHP at 1-877-440-5982.

MANDATORY NOTICES

Notice of Creditable Coverage — Important Notice From Milwaukee Public Schools

Prescription Drug Coverage and Medicare

Read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Milwaukee Public Schools (MPS) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- ❶ Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- ❷ MPS has determined that the prescription drug coverage offered by OptumRx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a medicare drug plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a medicare drug plan? Your (and/or your covered dependents) MPS health insurance coverage is on average as good as standard Medicare coverage and you (and/or your covered dependents) are not required to enroll in a Medicare prescription drug plan now to avoid paying a penalty (higher premium) for later enrollment. Remember that the premium for the Medicare plan is your responsibility to pay. The options for you and your eligible, covered dependents are as follows:

- a. You can maintain your MPS health insurance coverage and NOT enroll/pay for a Medicare prescription drug plan. If you do this, you will not have to pay the premium for a Medicare prescription drug plan and your prescription drug coverage will be provided by your MPS health insurance plan.
- b. You can maintain your MPS health insurance coverage and enroll/pay for a Medicare prescription drug plan. You will still be eligible to receive MPS health insurance plan benefits which cover other health insurance expenses in addition to prescription drug coverage. However, you have to pay the Medicare prescription drug plan premium.
- c. You can cancel your MPS health insurance coverage and enroll/pay for a Medicare prescription drug plan. However, your MPS health insurance plan covers other health insurance expenses in addition to prescription drug coverage and you CANNOT get your MPS coverage back. It is important that you consider this in any decision that you make to cancel your MPS coverage and purchase a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current MPS health coverage, be aware that you and your dependents will not be able to get this coverage back.

Please keep in mind that if you drop your MPS health plan and choose the Medicare prescription plan or any other Medigap plan, you and/or your covered dependents may not have the same access and level of benefits as MPS provides for prescription drugs, hospital, and other medical services. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area before deciding to drop your MPS health plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan? You should also know that if you drop or lose your current coverage with Milwaukee Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact OptumRx at 1-877-440-5982. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MPS changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

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

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

Date: 10/01/2025

Name of Entity/Sender: Milwaukee Public Schools

Contact—Position/Office: Department of Benefits, Pension & Compensation

P.O. Box 2181, Milwaukee, WI 53201-2181 • (414) 475-8441

General Notice of COBRA Continuation Coverage Rights

MILWAUKEE PUBLIC SCHOOLS PPO/INDEMNITY HEALTH PLAN, EXCLUSIVE PROVIDER ORGANIZATION (EPO) HEALTH PLAN, HIGH DEDUCTIBLE HEALTH PLAN (HDHP), SELF-INSURED INDEMNITY (PPO) DENTAL PLAN, AND THE DELTA DENTAL EPO DENTAL PLAN

Introduction

You are receiving this notice because you are eligible for coverage under the Milwaukee Public Schools PPO/Indemnity Health Plan, Exclusive Provider Organization (EPO) Health Plan, High Deductible Health Plan (HDHP), Self-Insured Indemnity (PPO) Dental Plan and/or the Delta Dental EPO Dental Plan (the Plan). This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or contact the Plan Administrator. The Plan Administrator is Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Milwaukee, Wisconsin 53208, (414) 475-8441, Fax: (414) 475-8562. COBRA continuation coverage for the Plan is administered by the Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Room 124, Milwaukee, Wisconsin 53208, (414) 475-8441.

This notice provides important information about your COBRA continuation coverage rights. Continuation coverage periods are specified for qualifying events for each person ("qualified beneficiary") entitled to elect COBRA continuation coverage for 18 or up to 36 months depending on the qualifying event. For more details, see section entitled "How long will continuation coverage last?" If you elect to exercise any rights to self-pay your coverage at the active employee rate while on an approved leave of absence (other than leave under state or federal Family and Medical Leave Acts), any such period of self-paid coverage will be deemed to be an election of COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage. Qualified beneficiaries include:

- ▶ Employee or former employee
- ▶ Spouse or former spouse of employee
- ▶ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ▶ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

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

What is COBRA Continuation Coverage? Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including Open Enrollment and special enrollment rights.

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct (MPS reserves the right to deny continuation coverage to you and your qualified beneficiaries under COBRA if MPS determines that the circumstances leading to termination of your employment establish gross misconduct.)

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

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

When is COBRA Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Milwaukee, Wisconsin 53208, (414) 475-8441, Fax (414) 475-8562.

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

How long will continuation coverage last? In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. If you elect to exercise any rights to self-pay your coverage at the active employee rate while on an approved leave of absence (other than leave under state or federal Family and Medical Leave Acts), any such period of self-paid coverage will be deemed to be an election of COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage.

In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time,
- A qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan
- A qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- The employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage? If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Milwaukee Public Schools, Department of Benefits, Pension & Compensation of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage (including any period of self-pay coverage deemed to be an election to exercise COBRA coverage) and must last at least until the end of the 18-month period of continuation coverage. Milwaukee Public Schools, Department of Benefits, Pension & Compensation must be notified within 60 days of the later of: (1) the SSA's determination or (2) when your COBRA coverage began (including any period of self-pay coverage deemed to be an election to exercise COBRA coverage), and in every case before the end of the first 18 months of continuation coverage. Notice can include official documentation from the SSA or a copy of the disability award, and notice can be provided by a Qualified Beneficiary or legal representative. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify Milwaukee Public Schools, Department of Benefits, Pension & Compensation, of that fact within 30 days of SSA's determination. Failure to notify MPS within this 30-day time period will result in cancellation of your coverage retroactive to the determination date you were deemed no longer disabled.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

How can you elect COBRA continuation coverage? To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

If you elect to exercise any rights to self-pay your coverage at the active employee rate while on an approved leave of absence (other than leave under state or federal Family and Medical Leave Acts), any such period of self-paid coverage will be deemed to be an election of COBRA continuation coverage and will count against your applicable period of COBRA continuation coverage.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed in your election notice. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost? Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage – If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Milwaukee, Wisconsin, 53208, Telephone (414) 475-8441, Fax (414) 475-8562, to confirm the correct amount of your first payment.

Periodic payments for continuation coverage – After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments shall be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the last day of the previous month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments – Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to:

**Milwaukee Public Schools
Department of Benefits, Pension & Compensation
5225 W. Vliet St., Milwaukee, WI, 53208**

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to: Milwaukee Public Schools, Department of Benefits, Pension & Compensation, 5225 W. Vliet St., Milwaukee, Wisconsin 53208, (414) 475-8441, Fax (414) 475-8562.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call 1-866-444-3272. For information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your rights and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:
MPS Department of Benefits, Pension & Compensation
5225 W. Vliet St., Room 124, Milwaukee, WI 53208
(414) 475-8441 • Fax (414) 475-8562

GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses.

Mandatory Social Security Number Reporting Requirement

A Federal law has been passed (Section 111 of Public Law 111-173) that requires you to provide your and your covered dependent's Social Security Numbers ("SSN") to your group health plan. As a covered participant of a group health plan, your SSN will likely be requested in order to meet the requirements of P.L. 110-173 if this information is not already on file with your group health plan. Your SSN will be reported to Medicare so that a determination can be made of which plan is to pay primary when dual coverage exists with Medicare. If you do not provide your and your dependent's SSN, your Employer may face a substantial penalty for non-compliance.

If you have any questions about this reporting requirement, please contact the Office of Human Resources, Department of Benefits, Pension & Compensation at (414) 475-8554.

Newborn's and Mothers' Health Protection Act of 1996

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

Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Milwaukee Public Schools health plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice in Open Enrollment to request enrollment. For more information contact the Office of Human Resources, Department of Benefits, Pension & Compensation at (414) 475-8554.

Notice of Opportunity To Enroll in Connection With Extension of Dependent Coverage to Age 26

For health plans beginning on or after September 23, 2010, young adults are allowed to stay on their parent's employer's health plan until they turn 26 years old. Before the health care law, insurance companies could remove enrolled children usually at age 19, sometimes older for full-time students. Now, most health plans that cover children must make coverage available to children up to age 26. By allowing children to stay on a parent's plan, the law makes it easier and more affordable for young adults to get health insurance coverage. Your children can join or remain on your plan even if they are:

- ▶ Married
- ▶ Not living with you
- ▶ Attending school
- ▶ Not financially dependent on you
- ▶ Eligible to enroll in their employer's plan

Notice of Privacy Practices

The privacy of your medical and dental information is important to us.

This notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information.

We are required by applicable Federal and State laws to maintain the privacy of your protected health information. Protected health information is defined as individually identifiable health information that is transmitted in electronic media or maintained in any medium described in the definition of electronic media in the Privacy Rules issued by the U.S. Department of Health and Human Services at 45 C.F.R. § 162.103 or transmitted or maintained in any other form or medium. The term “health information” in this notice includes any personal information that is created or received by a health or dental care provider or health or dental plan that relates to your physical, dental, or mental health condition, the provision of health or dental care to you, or the payment for such health or dental care. It does not include individually identifiable health information contained in education records covered by the Family Educational Rights and Privacy Act, records described in 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by the Milwaukee Board of School Directors.

We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect July 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Our Uses and Disclosures of Your Health Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose medical information about you as follows:

- **Treatment:** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **Payment:** We may use and disclose your health information to obtain payment of premiums, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have or to assist with payment of claims from doctors, hospitals and other providers for services delivered to you that are covered by your health or dental plan, to determine your eligibility for benefits, to assist with coordination of benefits, to obtain premiums, to disclose whether or not an individual is participating in the group health or dental plan and the like. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **Health Care Operations:** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use and disclose your health information to rate our risk and determine our premiums for your health or dental plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to manage our business, and the like.

We may use and disclose medical information about you as follows:

- **You and Your Authorization:** We must disclose your health information to you, as described below in Your Rights section of this notice. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your health information for any reason except those described in this notice. The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes if recorded by us; (ii) uses and disclosures of health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of health information; and (iv) other uses and disclosures not described in this Notice.
- **Your Family and Friends:** We may disclose to a family member, a friend, or other persons you indicate are involved in your care or payment for your care, your health information that is directly relevant to their involvement. We may use or disclose your name, location, and general condition or death to notify or help with notification of a family member, your personal representative, or other persons involved in your care about your situation. If you are present, we will give you the opportunity to object before we disclose your health information to these persons. If you are incapacitated or in an emergency, we may disclose your health information to these persons if we determine that the disclosure is in your best interest.
- **Underwriting:** We may receive your health information for premium rating or other activities relating to the creation, renewal or replacement of a contract of health or dental insurance or health or dental benefits. We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.
- **Disaster Relief:** We may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.
- **Death, Organ Donation:** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **Public Health and Safety:** We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your health information to a government agency authorized to oversee the health care system or government programs or its contractors and to public health authorities for public health purposes. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes.
- **Plan Sponsor:** We may disclose your protected health information to the Milwaukee Board of School Directors as plan sponsor to carry out plan administration functions that it performs upon certification by the plan sponsor that it has adopted provision to appropriately protect health information. We may disclose summary information about the members of the PPO Health Plan, Exclusive Provider Organization (EPO) Health Plan, High Deductible Health Plan (HDHP), Self-Insured Indemnity (PPO) Dental Plan and the Delta Dental EPO Dental Plan for the plan sponsor to use to obtain premium and cost information, or to decide whether to seek modifications of the PPO Health Plan, EPO Health Plan, HDHP, Self Insured Indemnity (PPO) Dental Plan and the Delta Dental EPO Dental Plan. We may also disclose eligibility, enrollment and disenrollment information to the Plan sponsor.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law. For example, we must disclose your health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings:** We may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.
- **Law Enforcement:** Under circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your health information to law enforcement officials. We may disclose limited health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security:** We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Your Rights With Respect to Your Health Information

- **Access:** You have the right to review or obtain copies of your health information in our possession, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$0.25 for each page, \$10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.
- **Disclosure Accounting:** You have the right to receive an accounting of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information, (i) made prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- **Restriction Requests:** You have the right to ask to restrict our uses and disclosures of your health information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or others who are involved in your health care or payment for your health care. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We are also required to agree to a request to restrict disclosure of your health information to a health plan if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the health information pertains solely to a health care item or service for which you or a person other than the health plan on your behalf, had paid in full. Any request to restrict must be made in writing and should identify (i) the information to be restricted; (ii) the type of restriction being requested (for example, the use or disclosure, or both), and (iii) to whom the limits should apply.
- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your health information by alternative means or to an alternative location. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Electronic Notice:** If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.
- **Notification of Breach:** We are required to notify you of any breach of your unsecured protected health information.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information as listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

MPS Department of Benefits, Pension & Compensation
5225 W. Vliet St., Room 124, Milwaukee, WI 53208
(414) 475-8554 • Fax (414) 475-8562

Plan Status: Non-Grandfathered Plan

Your MPS plan is classified as Non-Grandfathered.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, Wisconsin may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in Wisconsin, you can contact the Wisconsin Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in the following state you may be eligible for assistance paying your employer health plan premiums. The following information is current as of July 31, 2025. Contact your State for more information on eligibility.

WISCONSIN – Medicaid and CHIP

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

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U. S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U. S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565
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Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, or 60 days after the birth, adoption or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact the Office of Human Resources, Department of Benefits, Pension & Compensation at (414) 475-8554.

Note: Limitations apply to retiree health plans – please see pages 11-15.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

ACA Marketplace Notice

PART A GENERAL INFORMATION

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

What Is the Health Insurance Marketplace?

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

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

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

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

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

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

– Continued on following page –

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

²An employer-sponsored or other employment-based health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency.

Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the Department of Benefits, Pension & Compensation at (414) 475-8554. For more information regarding the Marketplace please call 1-800-318-2596.

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

PART B INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Milwaukee Board of School Directors		4. Employer Identification Number (EIN) 39-6003457	
5. Employer address 5225 W. Vliet St.		6. Employer phone number 414-475-8217	
7. City Milwaukee	8. State WI	9. ZIP code 53208	
10. Who can we contact about employee health coverage at this job? The Department of Benefits, Pension & Compensation			
11. Phone number (if different from above)		12. Email address MPSEmployeeBenefits@milwaukee.k12.wi.us	

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

As your employer, we offer a health plan to:

- ☐ All employees.
- ☒ Some employees. Eligible employees are:
Employees regularly scheduled to work in benefit eligible positions of 30 hours or more per week.

With respect to dependents:

- ☒ We do offer coverage. Eligible dependents are:
The following individuals who meet specific eligibility requirements include spouse, dependent child, grandchild, legal ward. For more information, visit the <http://mps.milwaukee.k12.wi.us/en/home.htm> > Careers > Resources > Employee Benefits Summary.
- ☐ We do not offer coverage.
- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process.

Summary of Benefits and Coverage

In accordance with the requirements of the Affordable Care Act (“ACA” also known as the health care reform law), a Summary of Benefits and Coverage (“SBC”) is now available on mConnect and on the MPS Website at <https://mpsmke.com>, click Careers > Employee Benefits Summary.

What is a Summary of Benefits and Coverage (SBC)? It is an eight-page document that is mandated by the government that presents key, standardized information about your current health plan coverage. The government’s intent is to provide a concise document explaining, in plain language, simple and consistent information about health plan benefits and coverage. It summarizes the key features of the health plan, such as the covered benefits, cost-sharing provisions, coverage limitations and provides two coverage examples. The content and formatting requirements are strict and used industry-wide throughout the United States to allow easy comparison of coverage options between plans and carriers.

What is the Glossary referred to in the SBC? It is a glossary compiled by the government of commonly used definitions of health coverage and medical terminology, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions for a particular health plan. Some of the terms also might not have exactly the same meaning when used in a policy or a plan, and in any such case, the policy or plan governs. The Glossary is mandated to be provided in connection with the SBC and cannot be modified.

How can I access the SBC and the Glossary on the MPS website? You do not need a password to access the website to obtain the SBC that pertains to the MPS health plan you are enrolled in. Active employees and retirees may go to the MPS Website, <https://mpsmke.com>, click Careers > Employee Benefits Summary. If you want more detailed information about your benefits, please contact UnitedHealthcare at 1-877-440-5982 for medical and pharmacy benefits. We thank you for your continued cooperation.

Women’s Health & Cancer Rights Acts of 1998

On October 21, 1998, Congress passed a law entitled the “Women’s Health & Cancer Rights Act of 1998.” The Act requires that all health plans offering mastectomy coverage shall also provide benefits for the following services:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

Your MPS Health Plan provides breast reconstruction benefits and will continue to provide covered benefits and services that are consistent with this law. These benefits are provided in a manner which is determined in consultation with your doctor. Coverage for these services is subject to all of the same limitations, exclusions and cost-sharing provisions that apply generally (including annual deductibles and coinsurance provisions) to all other services provided under your policy. Written notice of the availability of such coverage shall be delivered to participants upon enrollment and annually thereafter.

Additional Notices

1095-C Employer-Provided Health Insurance Offer and Coverage for Active Employees, Applicable COBRA Participants and Non-Medicare Retirees*

In accordance with the requirements of the Affordable Care Act (ACA), and the Paperwork Burden Reduction Act, Milwaukee Public Schools ("MPS") is no longer required to mail the 1095-C to employees, applicable COBRA members or non-Medicare retirees who were full-time employees or were covered under an MPS non-Medicare plan for one or more months of the 2025 calendar year. The 1095-C form is used to report your and your dependents' offer of health coverage and enrollment in health coverage from MPS. MPS will continue to report this information for each covered individual to the IRS.

Part I APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.		Part II Employee Offer of Coverage		Part III Covered Individuals	
Milwaukee Public Schools 5225 W Villet St Room 124 Milwaukee WI 53208 414/475-8217		Plan Start Mo. (enter 2-digit mo.): 01		(a) Name of covered individual(s) First name, middle initial, last name	
Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095C for instructions and the latest information.		All 12 Months: Jan 1A \$ 2G, Feb 1A \$ 2G, Mar 1A \$ 2G, Apr 1A \$ 2G, May 1A \$ 2G, June 1A \$ 2G, July 1A \$ 2G, Aug 1A \$ 2G, Sept 1A \$ 2G, Oct 1A \$ 2G, Nov 1A \$ 2G, Dec 1A \$ 2G		(b) SSN or other TIN	
APPLICABLE LARGE EMPLOYER'S identification number (EIN)		EMPLOYEE'S social security number (SSN): XXX-XX-		(c) DOB (if SSN or other TIN is not available)	
				(d) Covered all 12 mos.	
				(e) Months of coverage: Jan, Feb, Mar, Apr, May, June, July, Aug, Sept, Oct, Nov, Dec	

A paper copy of the 1095-C form will be provided to individuals only upon request. When filing your tax return, you can use this form to report your insurance coverage during the year to comply with the Affordable Care Act.

MPS will post the required notice of availability on our website by March 2, 2026, with instructions on how to request a copy of the 1095-C form. Requests for 1095-C forms will be fulfilled by January 31, or 30 days after the date of the request whichever is later. Covered individuals can go to <https://mpsmke.com>, click Careers > Employee Benefits Summary to view the notice once it is posted. Active employees will be able to view their 1095-C electronically via Self-Service once it is available. See example of Form 1095-C.

*Information current as of the date of publication. For informational purposes only – MPS cannot provide tax advice.

Appeal Procedure for Health Plans (PPO, EPO, HDHP)

Claims Denials and Appeal — In general, if a claim for benefits is denied in part or in whole, call UnitedHealthcare (UHC) at the number on your ID card (1-877-440-5982) before requesting a formal appeal. If UHC cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim — If you wish to appeal a denied pre-service request for benefits or for a post-service claim, you or your authorized representative must submit your appeal in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request

You may draft your written communication including the information listed above or you may use a Member Service Request Form located on the UHC member website. Log-in under your user name and password, click on the Claims & Accounts > click on Submit a Claim > under "View More Forms" select Medical Appeal & Grievances Form. You or your authorized representative may send this written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 30432, Salt Lake City, UT 84130-0432

You do not need to submit urgent care appeals in writing. For Urgent Care requests for benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card (1-877-440-5982) to request an appeal.

Review of an Appeal — UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal — Your health plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from MPS. Instructions are included with the first level appeal determination letter from UnitedHealthcare. For a second level appeal, please include your written appeal request, a copy of the first appeal denial determination letter from UnitedHealthcare, and any additional documentation that supports your second level appeal request. Second level appeals can be sent to:

MPS Department of Benefits, Pension & Compensation
5225 W. Vliet St., Room 124, Milwaukee, WI 53208

Voluntary External Review — If after exhausting the two levels of appeal you are not satisfied with the final determination, you may choose to participate in the voluntary external review program. Any request for external review must be filed within 125 days after you receive UnitedHealthcare's final decision on an internal claims appeal. You can submit a request for external review by contacting UnitedHealthcare at:

UnitedHealthcare – Appeals
P.O. Box 30432, Salt Lake City, UT 84130-0432
1-877-440-5982

Dependent Status Change Required Notices

Important Notice For Plan Participants — You are required to notify MPS Department of Benefits, Pension & Compensation of the following insurance information and events as they occur throughout the year to remove ineligible dependents from your plans. Notification is required within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage).

If you divorce:

- Your ex-spouse and your step-child(ren) from that marriage are no longer eligible to be covered as dependents under your MPS health plan
- **You must remove ineligible dependents** from your MPS health plan by contacting MPS and completing an MPS Benefits Termination Form
- If your ineligible dependents are kept on your MPS health plan, you can face penalties up to and including loss of coverage and repayment to MPS for claims/premiums paid for ineligible dependents
- Failure to notify MPS within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) may also result in the loss of rights to self-pay for COBRA continuation coverage

If your spouse or other covered dependent dies:

- **You must notify MPS in writing** so we can remove them from your MPS health plan
- Upon receipt of your notification, we will send you an MPS Benefits Termination Form that you must complete. We accept your signed & completed form as your notice; we do not require a death certificate

If you are enrolled/changed/cancelled other medical or prescription coverage:

- **For the EPO, PPO, or HDHP you must notify UnitedHealthcare** by calling 1-877-440-5982 as soon as possible when the change occurs
- **For the Medicare Advantage plan notify UnitedHealthcare** at 1-866-487-9303 as soon as possible when the change occurs
- You can avoid service problems since MPS benefit plans coordinates your benefits with other plans

If you are under Age 65 & Medicare eligible due to a disability:

● **You must inform MPS in writing** and send a copy of your Medicare Card

If you are eligible for Medicare and did not enroll:

● **You must enroll in Medicare Part B** if you are retired, or are the spouse of a retiree, and eligible, regardless of whether or not you are enrolled in Social Security.

Remember, it is your responsibility to notify MPS within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) to remove ineligible dependents from your MPS health and dental plans.

If you have any questions, please contact:

**MPS Department of Benefits, Pension & Compensation
5225 W. Vliet St., Room 124, Milwaukee, WI 53208
(414) 475-8554 • Fax (414) 475-8562**

NOTICE

MPS reserves its rights to pursue appropriate disciplinary action against you, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. It is your responsibility to notify MPS Department of Benefits, Pension & Compensation within 31 days (60 days for birth, adoption, loss of Medicaid or CHIP coverage) to remove your ineligible dependent(s) from your MPS health plan.

Notice of Establishment of the Milwaukee Board of School Directors Post-Employment Benefits Trust

On May 27, 2010 the Milwaukee Board of School Directors authorized the establishment of the Milwaukee Board of School Directors Post-Employment Benefits Trust under Internal Revenue Code Section 115 for the purpose of funding costs associated with post-employment benefits other than pension; e.g., health and life insurance. Employees can view the Trust Agreement by making a written request to Milwaukee Public Schools, Department of Benefits, Pension & Compensation.

Subrogation and Reimbursement Notice for MPS EPO/PPO/HDHP Plans

How your benefits are impacted if you suffer a sickness or injury caused by a third party? The Plan has a right to subrogation and reimbursement.

Right of Recovery — The Plan has the right to recover benefits it has paid on you or your dependent's behalf that were made in error; or due to a mistake in fact; or advanced during the time period of meeting the calendar year deductible; or advanced during the time period of meeting the Out-Of-Pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will require that the overpayment be returned when requested, or reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of the deductible and/or meeting the Out-Of-Pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan; and conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation — The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident. The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement — The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Third Parties — The following persons and entities are considered third parties: a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages; any insurer or other indemnifier of any person or entity who caused the sickness, injury or damages; Milwaukee Public Schools in workers' compensation cases; or any person or entity who is or may be obligated to provide you with benefits or payments under underinsured or uninsured motorist insurance; medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise); workers' compensation coverage; or any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions — As a covered person, you agree to the following:

- ❶ The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party;
- ❷ The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right;
- ❸ Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

Benefits paid by the Plan may also be considered to be benefits advanced. You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- ❶ Complying with the terms of this section;
- ❷ Providing any relevant information requested;
- ❸ Signing and/or delivering documents at its request;
- ❹ Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
- ❺ Responding to requests for information about any accident or injuries;
- ❻ Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
- ❼ Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval. Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a sickness or injury caused by a third party.

The Plan's rights will not be reduced due to your own negligence.

The Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.

The provisions of this section apply to the parents, guardian or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate and your heirs.

Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

If a third party causes you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a covered person.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

IMPORTANT NOTICE/DISCLAIMER

This summary provides highlights of the Milwaukee Public Schools (MPS) health benefits offered to benefit-eligible retirees of MPS. This publication describes these benefits in general terms only as of the publication date indicated and is not intended to be a complete description of coverage. All benefit and eligibility provisions described herein are subject to, and subordinate to, the terms and provisions of the master plan document or contract for each plan, Board policies and procedures, and State and Federal law, and are not intended to, and shall not be construed to, create any rights that in any manner exceed or modify the terms and conditions of the benefit plans as set forth in or mandated by these other sources. MPS reserves the right to modify, amend, repeal or terminate any provision or plan summarized herein, and any Board policy or procedure, consistent with State or Federal law, at any time with or without notice. This summary and any of the sources referenced herein are not intended and should not be construed to be a contract of employment, express or implied.

NONDISCRIMINATION NOTICE

It is the policy of the Milwaukee Public Schools, as required by section 118.13, Wisconsin Statutes, that no person will be denied admission to any public school or be denied the benefits of, or be discriminated against in any curricular, extracurricular, pupil services, recreational or other program or activity because of the person's sex, race, color, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability.

This policy also prohibits discrimination under related federal statutes, including Title VI of the Civil Rights Act of 1964 (race, color, and national origin), Title IX of the Education Amendments of 1972 (sex), and Section 504 of the Rehabilitation Act of 1973 (disability), and the Americans with Disabilities Act of 1990 (disability).

The following individuals have been designated to handle inquiries regarding student non-discrimination policies:

For section 118.13, Wisconsin Statutes, federal Title IX: Matthew Boswell, Director, Department of Student Services, Room 133, Milwaukee Public Schools, 5225 W. Vliet St., P.O. Box 2181, Milwaukee, Wisconsin, 53201-2181 (414) 475-8027.

For Section 504 of the Rehabilitation Act of 1973 (Section 504), federal Title II: Travis Pinter, 504/ADA Coordinator for Students, MPS Department of Specialized Services, 6620 W. Capitol Drive. (414) 438-3677.

EMPLOYMENT NONDISCRIMINATION NOTICE

Milwaukee Public Schools is committed to equal employment opportunity and non-discrimination as required by the law for all individuals in the MPS workplace regardless of race, color, ancestry, religion, gender, sex, national origin, disability, age, creed, sexual orientation, marital status, veteran status, or any other legally protected characteristic or legally protected activity (e.g., participation in the complaint process). MPS will not tolerate adverse treatment based on a legally protected characteristic or legally protected activity involving equal employment opportunity.

Jamie Bergener, (414) 475-8993; bergenj@milwaukee.k12.wi.us, Interim Manager, Employee Rights Administrative Department (ERAD), has been designated to respond to requests for disability-related job accommodations. Yashica Spears, (414) 475-8427; spearsyq@milwaukee.k12.wi.us, EEO Compliance Specialist, ERAD, has been designated to respond to internal complaints regarding employment discrimination. ERAD can be contacted in the Office of Human Resources at Milwaukee Public Schools, 5225 W. Vliet Street, Room 128, P.O. Box 2181, Milwaukee, WI 53201-2181.

Language Assistance Services: UnitedHealthcare EPO, PPO, and HDHP member toll-free #: 1-877-440-5982 • Medicare Advantage Plan member toll-free #: 1-866-487-9303

Spanish Languages Services: ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

IMPORTANT CONTACTS

Vendor	Phone Number	Customer Service Hours	Website
UnitedHealthcare Advocate 4Me for Non-Medicare Retirees	1-877-440-5982	Monday – Friday 7:00 a.m. – 8:00 p.m.	Log on to: https://myuhc.com
UnitedHealthcare (EPO, PPO, and HDHP) and OptumRx	1-877-440-5982	Monday – Friday 7:00 a.m. – 8:00 p.m.	https://myuhc.com For EPO: Click “Find a Provider”; choose “Medical Directory,” then choose “Employer and Individual Plans,” then choose “Choice.” https://myuhc.com for PPO and HDHP: Click “Find a Provider” then choose “Medical Directory” then choose “Employer and Individual Plans” then choose “Choice Plus.”
MPS Group Medicare Advantage Plan (Administered by UHC)	1-866-487-9303	8:00 a.m. – 8:00 p.m., local time Monday – Friday	https://retiree.uhc.com
Renew Active® by UnitedHealthcare	1-866-487-9303	8:00 a.m. – 8:00 p.m., local time Monday – Friday	https://retiree.uhc.com To find facilities in your area, visit: https://uhcrenewactive.com/home

Appendix A: Health Plan Design

BENEFITS / SERVICES <i>Subject to Medical Necessity</i>	MPS PPO UHC – Choice Plus IN-NETWORK	MPS PPO UHC Choice Plus OUT-OF-NETWORK	MPS EPO UHC – Choice IN-NETWORK ONLY	MPS HDHP UHC – Choice Plus IN-NETWORK	MPS HDHP UHC – Choice Plus OUT-OF-NETWORK
ANNUAL PLAN DEDUCTIBLE	Individual: \$750 Family: \$2,250 (3 individuals) Plan Pays 80%	Individual: \$1,500 Family: \$4,500 (3 individuals) Plan Pays 50%	Individual: \$350 Family: \$1,050 (3 individuals) Plan Pays 80%	Individual: \$1,700 Family: \$3,400 Plan Pays 80%	Individual: \$3,400 Family: \$6,800 Plan Pays 50%
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM	Includes deductible, coinsurance, medical co-pays; <u>Excludes prescription co-pays.</u> Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance, medical co-pays; <u>Excludes prescription co-pays.</u> Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance, medical co-pays; <u>Excludes prescription co-pays.</u> Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance and covered prescription cost share. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.	Includes deductible, coinsurance and covered prescription cost share. Once the OOP maximum is met, coverage is 100% for the remainder of the calendar year.
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM	Single: \$3,250 Family: \$9,750	Single: \$4,500 Family: \$13,500	Single: \$1,350 Family: \$4,050	Single: \$3,400 Family: \$6,800	Single: \$6,800 Family: \$13,600
PHARMACY COVERAGE	— (Prescription drug coverage provided by OptumRx Participating Pharmacies) —				
PHARMACY OUT-OF-POCKET MAXIMUM	Individual: \$4,100 Family: \$4,950	N/A	Individual: \$6,000 Family: \$10,650	Included in Medical Out-Of-Pocket Maximum	N/A
RETAIL PHARMACY	Tier 1: Generic \$8 co-pay Tier 2: Preferred Brand-name 10% with a \$25 Minimum co-pay Tier 3: Non-preferred Brand-name 20% with a \$50 Minimum co-pay Multi-Source Brand: Member-Pay-Difference*	None	Tier 1: Generic \$8 co-pay Tier 2: Preferred Brand-name 10% with a \$25 Minimum co-pay Tier 3: Non-preferred Brand-name 20% with a \$50 Minimum co-pay Multi-Source Brand: Member-Pay-Difference*	80% after Deductible None	None
RETAIL PREVENTIVE PHARMACY (Applies to HDHP – Refer to preventive drug list available on mConnect/MPS website)	Same as Retail Pharmacy	None	Same as Retail Pharmacy	Tier 1: Generic \$8 co-pay Tier 2: Preferred Brand-name 10% with a \$25 Minimum co-pay Tier 3: Non-preferred Brand-name 20% with a \$50 Minimum co-pay Multi-Source Brand: Member-Pay-Difference*	None
*Member-Pay-Difference: Member pays the \$8 Retail Generic (\$16 Mail Order Generic) co-pay plus the gross cost difference between the Brand and equivalent Generic. This additional cost is excluded from the OOP limit.					

BENEFITS / SERVICES <i>Subject to Medical Necessity</i>	MPS PPO <i>UHC – Choice Plus</i> IN-NETWORK	MPS PPO <i>UHC Choice Plus</i> OUT-OF-NETWORK	MPS EPO <i>UHC – Choice</i> IN-NETWORK ONLY	MPS HDHP <i>UHC – Choice Plus</i> IN-NETWORK	MPS HDHP <i>UHC – Choice Plus</i> OUT-OF-NETWORK
MAIL ORDER PHARMACY	Tier 1: Generic \$16 co-pay Tier 2: Preferred Brand-name \$50 co-pay Tier 3: Non-preferred Brand-name \$100 co-pay Multi-Source Brand: Member-Pay-Difference*	None	Tier 1: Generic \$16 co-pay Tier 2: Preferred Brand-name \$50 co-pay Tier 3: Non-preferred Brand-name \$100 co-pay Multi-Source Brand: Member-Pay-Difference*	80% after deductible (pricing discounts at mail order)	None
MAIL ORDER PREVENTIVE PHARMACY	Same as Mail Order Pharmacy	None	Same as Mail Order Pharmacy	Tier 1: Generic \$16 co-pay Tier 2: Preferred Brand-name \$50 co-pay Tier 3: Non-preferred Brand-name \$100 co-pay Multi-Source Brand: Member-Pay-Difference*	None
*Member-Pay-Difference: Member pays the \$8 Retail Generic (\$16 Mail Order Generic) co-pay plus the gross cost difference between the Brand and equivalent Generic. This additional cost is excluded from the OOP limit.					

AMBULANCE	80% after deductible	80% after deductible**	80% after deductible	80% after deductible	80% after deductible**
HOSPITAL SERVICES <i>Inpatient Outpatient (includes outpatient therapeutic treatments) Surgery Physician In-Hospital Services</i>	80% after deductible	50% after deductible**	80% after deductible	80% after deductible	50% after deductible**
PHYSICIAN SERVICES <i>Office Visits – Primary Care Physician (Non-Surgical)</i>	100% after \$20 co-pay per visit	50% after deductible	100% after \$20 co-pay per visit	80% after deductible	50% after deductible**
ROUTINE PHYSICALS	100% after \$20 co-pay per visit SEE PREVENTIVE CARE	50% after deductible	100% after \$20 co-pay per visit SEE PREVENTIVE CARE	100% For Preventive Care; 80% after deductible if not covered under Preventive	50% after deductible
IMMUNIZATIONS	100% after \$20 co-pay; \$35 co-pay if Specialist SEE PREVENTIVE CARE	50% after deductible	100% after \$20 co-pay; \$35 co-pay if Specialist SEE PREVENTIVE CARE	100% for Preventive Care	50% after deductible
PREVENTIVE CARE	100% of eligible expenses	50% after deductible	100% of eligible expenses	100% of eligible expenses	50% after deductible
SPECIALISTS <i>(Office Visits)</i> Other Physician Services	\$35 co-pay per office visit.	50% after deductible	\$35 co-pay per office visit.	80% after deductible	50% after deductible**

BENEFITS / SERVICES <i>Subject to Medical Necessity</i>	MPS PPO <i>UHC – Choice Plus</i> IN-NETWORK	MPS PPO <i>UHC Choice Plus</i> OUT-OF-NETWORK	MPS EPO <i>UHC – Choice</i> IN-NETWORK ONLY	MPS HDHP <i>UHC – Choice Plus</i> IN-NETWORK	MPS HDHP <i>UHC – Choice Plus</i> OUT-OF-NETWORK
CONTRACEPTIVES	100% no deductible as specified under Health Care reform.	50% after deductible	100% no deductible as specified under Health Care Reform.	100% no deductible as specified under Health Care Reform	50% after deductible
DENTAL SERVICES Oral Surgery Accident Only	80% after deductible-specific list of oral procedures covered. Dental implants excluded. 80% after deductible and within 72 hrs of accident	50% after deductible-specific list of oral procedures covered.** Dental implants excluded. 80% after deductible and within 72 hrs of accident	80% after deductible-oral surgery limited to surgical removal of impacted wisdom teeth only. Dental implants excluded. 80% after deductible and within 72 hrs of accident	80% after deductible Oral surgery limited to surgical removal of impacted wisdom teeth only. Dental implants excluded.	50% after deductible** Oral surgery limited to surgical removal of impacted wisdom teeth only. Dental implants excluded.
DURABLE MEDICAL EQUIPMENT <i>(Including cochlear implants)</i>	80% after deductible	50% after deductible**	80% after deductible; single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.	80% after deductible; Single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.	50% after deductible** Single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination.
EMERGENCY HEALTH SERVICES	100% after \$150 co-payment per visit	100% after \$150 co-payment per visit**	100% after \$125 co-payment per visit	80% after deductible	80% after deductible**
FERTILITY SOLUTIONS <i>(including artificial insemination, assisted reproductive technologies, and in vitro fertilization)</i> To access this benefit, call 1-866-774-4626 or visit http://myuhc.phs.com/fertility	\$35 co-payment per office visit; 80% after deductible Lifetime maximum of \$30,000; combined in and out-of-network	50% after deductible** Lifetime maximum of \$30,000; combined in and out-of-network	\$35 co-pay per office visit. 80% after deductible Lifetime maximum of \$2,000	Exclusion: Health services and associated expenses for infertility treatments including assisted reproductive technology regardless of reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.	Exclusion: Health services and associated expenses for infertility treatments including assisted reproductive technology regardless of reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
HEARING AIDS <i>For dependent children under 18 years of age. Limit of one hearing aid per ear every three years.</i>	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible
HOME HEALTH CARE	80% after deductible Up to 120 visits per calendar year, combined in and out-of-network.	50% after deductible** Up to 120 visits per calendar year, combined in and out-of-network.	80% after deductible, up to maximum of 60 visits when approved in advance by UHC Care Coordination.	80% after deductible, up to maximum of 60 visits when approved in advance by UHC Care Coordination.	50% after deductible** Up to maximum of 60 visits when approved in advance by UHC Care Coordination.

BENEFITS / SERVICES <i>Subject to Medical Necessity</i>	MPS PPO <i>UHC – Choice Plus</i> IN-NETWORK	MPS PPO <i>UHC Choice Plus</i> OUT-OF-NETWORK	MPS EPO <i>UHC – Choice</i> IN-NETWORK ONLY	MPS HDHP <i>UHC – Choice Plus</i> IN-NETWORK	MPS HDHP <i>UHC – Choice Plus</i> OUT-OF-NETWORK
HOSPICE CARE	80% after deductible Lifetime maximum up to 45 days for inpatient care, combined & out-of-network	50% after deductible** Lifetime maximum up to 45 days for inpatient care, combined & out-of-network	80% after deductible Lifetime maximum up to 360 days.	80% after deductible	50% after deductible**
LAB, X-RAY, DIAGNOSTICS and THERAPEUTIC TREATMENTS – OUTPATIENT <i>(including allergy testing, chemotherapy, MRI, CT, etc.) For preventive lab/x-ray procedures, refer to Preventive Care services category.</i>	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible**
MENTAL HEALTH SERVICES <i>Inpatient</i> <i>Outpatient (includes transitional treatment)</i>	80% after deductible 100% after \$20 co-payment per visit	50% after deductible** 50% after deductible**	80% after deductible 100% after \$20 co-payment Prior authorization through UHC Designee is required	80% after deductible 80% after deductible	50% after deductible** 50% after deductible**
OBESITY/WEIGHT LOSS <i>(when medically necessary & must meet certain criteria)</i>	\$35 co-pay per office visit	50% after deductible**	Not covered	Not covered	Not covered
PREGNANCY-MATERNITY SERVICES	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category. For services provided in the physician's office, a co-payment will only apply to the initial visit.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category. For services provided in the physician's office, a co-payment will only apply to the initial office visit.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.
PRIVATE DUTY NURSING <i>(outpatient only) Limit of 70 visits per year, combined in and out-of-network.</i>	80% after deductible	50% after deductible**	N/A	N/A	N/A
PROSTHETIC/ORTHOTIC DEVICES	80% after deductible please call UHC for restrictions on foot orthotics.	50% after deductible** Please call UHC for restrictions on foot orthotics.	80% after deductible; single device every three years as specified and approved through UHC Care Coordinator. Orthotics not covered.	80% after deductible Orthotics not covered.	50% after deductible** Orthotics not covered.

BENEFITS / SERVICES <i>Subject to Medical Necessity</i>	MPS PPO <i>UHC – Choice Plus</i> IN-NETWORK	MPS PPO <i>UHC Choice Plus</i> OUT-OF-NETWORK	MPS EPO <i>UHC – Choice</i> IN-NETWORK ONLY	MPS HDHP <i>UHC – Choice Plus</i> IN-NETWORK	MPS HDHP <i>UHC – Choice Plus</i> OUT-OF-NETWORK
REHABILITATION SERVICES-OUTPATIENT THERAPY (INCLUDING PT, OT, SPEECH, ETC.) and MANIPULATIVE TREATMENT <i>All care coordinated by Optum of UHC.</i>	100% after \$20 co-payment per visit	50% after deductible**	100% after \$20 co-pay; limit of 20 visits of each: PT, OT, speech, pulmonary, and cognitive rehab, and 36 visits of cardiac rehabilitation per calendar year.	80% after deductible Limit of 20 visits of each: PT, OT, speech, pulmonary, and cognitive rehab, and 36 visits of cardiac rehabilitation per calendar year.	50% after deductible** Limit of 20 visits of each: PT, OT, speech, pulmonary, and cognitive rehab, and 36 visits of cardiac rehabilitation per calendar year.
SCOPIC PROCEDURES – OUTPATIENT DIAGNOSTIC & THERAPEUTIC <i>For preventive scopic procedures, refer to Preventive Care services category.</i>	80% after deductible	50% after deductible	80% after deductible	80% after deductible	50% after deductible
SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY	80% after deductible Up to 120 days per calendar year, combined in and out-of-network.	50% after deductible** Up to 120 days per calendar year, combined in and out-of-network.	80% after deductible, maximum of 30 days per inpatient stay for care in conjunction with discharge from hospital and 60 days per calendar year for inpatient rehabilitation facility	80% after deductible Combined limit in and out-of-network of 60 days per year	50% after deductible** Combined limit in and out-of-network of 60 days per year
SUBSTANCE USE DISORDER SERVICES <i>Inpatient Outpatient (Includes transitional treatment)</i>	80% after deductible 100% after \$20 co-payment per visit	50% after deductible** 50% after deductible**	80% after deductible 100% after \$20 co-payment per visit	80% after deductible 80% after deductible	50% after deductible** 50% after deductible**
TEMPORO-MANDIBULAR JOINT SERVICES DIAGNOSTIC and NON-SURGICAL TREATMENT	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**	Depending on where the covered health service is provided, benefits will be the same as those stated under each covered health service category.**
TRANSPLANTATION SERVICES	80% after deductible, services must be received at a Designated Facility; in conjunction with National Program for Medical Excellence.	50% after deductible in conjunction with National Program for Medical Excellence.**	80% after deductible Pre-Service Notification Required. Must be received at a designated facility**	80% after deductible Pre-Service Notification Required. Must be received at a designated facility**	Non-network benefits are not available

BENEFITS / SERVICES <i>Subject to Medical Necessity</i>	MPS PPO <i>UHC – Choice Plus</i> IN-NETWORK	MPS PPO <i>UHC Choice Plus</i> OUT-OF-NETWORK	MPS EPO <i>UHC – Choice</i> IN-NETWORK ONLY	MPS HDHP <i>UHC – Choice Plus</i> IN-NETWORK	MPS HDHP <i>UHC – Choice Plus</i> OUT-OF-NETWORK
URGENT CARE/ WALK-IN CLINIC	\$35 co-payment per visit	50% after deductible	\$35 co-pay for designated urgent care centers and doctor offices.	80% after deductible	50% after deductible
VISION EXAMINATION (ROUTINE)	Not Covered	Not Covered	100% after \$20 co-payment per visit, limited to 1 exam every 2 years	Not Covered	Not Covered
**Preauthorization is required or benefits will be reduced. If you are admitted to a Hospital as a result of an Emergency, you must notify UHC within 2 business days of the admission. In addition to the above categories, preauthorization by the member is required for out-of-network services for the following: clinical trials, congenital heart disease services, genetic testing-BRCA, neurological disorders/mental health services for autism spectrum disorder, reconstructive procedures and therapeutics. Please contact UnitedHealthcare for specific preauthorization requirements.					

Appendix B: MPS Group Medicare Advantage Plan Details

Special Note for Retirees and their spouses/dependents becoming Medicare eligible mid-year: Since the MPS Group Medicare Advantage plan is a separate and distinct plan, when you move from either the EPO, PPO or HDHP mid-year, your deductible and Out-Of-Pocket limit met under those plans does not transfer to the MPS Group Medicare Advantage plan. Under the MPS Group Medicare Advantage plan, your deductible is \$0 and your Out-Of-Pocket limit expenses would start over for the remainder of the calendar year.

DESCRIPTION	IN NETWORK & OUT-OF-NETWORK
Annual Medical Deductible	None
Annual Medical Out-Of-Pocket Maximum (Does not include Prescription co-pays)	\$1,350
PHYSICIAN SERVICES	
Primary Care Physician Office Visit (includes Non-MD office visits)	\$20
Specialist Office Visit	\$35
Chiropractic Visit (Medicare-covered)	\$20
Podiatry Visit (Medicare-covered)	\$35
Eye Exam (Medicare-covered)	\$35
Hearing Exam (Medicare-covered)	\$35
INPATIENT SERVICES	
Inpatient Hospital Stay Benefit Period in days. (A “benefit period” begins the first day of admission and ends when the member hasn’t received any hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins and the co-pay cycle starts over.)	Unlimited
Inpatient Hospital Stay	\$0 Per Admit
Skilled Nursing Facility Care - prior hospital stay requirement waived?	Yes
Skilled Nursing Facility Care - Benefit Period (In days)	100 Days
Skilled Nursing Facility Care	\$0 Per Day, Days 1–20 \$50 per day, 21–100
Inpatient Mental Health Lifetime Maximum number of days	Unlimited
Inpatient Mental Health in a Psychiatric Hospital	\$0 Per Admit
OUTPATIENT SERVICES	
Outpatient Surgery	\$100
Outpatient Hospital Services	\$100
Outpatient Mental Health/Substance Abuse (Individual Visit)	\$20
Outpatient Mental Health/Substance Abuse (Group Visit)	\$20
Partial Hospitalization (Mental Health Day Treatment) per day	\$20
Comprehensive Outpatient Rehabilitation Facility (CORF)	\$20
Occupational Therapy	\$20
Physical Therapy and Speech/Language Therapy	\$20
Cardiac/Pulmonary Rehabilitation	\$20
Kidney Dialysis	20%
Dental Services (Medicare-covered)	\$35
AMBULANCE/EMERGENCY ROOM/URGENT CARE	
Ambulance Services	\$50
Emergency Room (Includes Worldwide Coverage)	\$65
Urgently Needed Care (Includes Worldwide Coverage)	\$35

DESCRIPTION	IN NETWORK & OUT-OF-NETWORK
PART B DRUGS AND BLOOD	
Part B Drugs – Immunosuppresses, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors, Antigens, Outpatient Injectable Medications Administered in a Physician's Office	20%
Chemotherapy Drugs	20%
Blood	\$0
DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES	
Durable Medical Equipment	20%
Prosthetics	20%
Orthotics – covered for those with diabetes, foot disease, doctor-deemed medically necessary by a provider	20%
Diabetic Shoes and Inserts	20%
Medical Supplies	20%
Diabetes Monitoring Supplies – preferred products One-Touch and Accu –Check products	\$0
HOME HEALTHCARE AGENCY & HOSPICE	
Home Health Services	\$0
Hospice (Medicare-covered)	\$0
PROCEDURES	
Clinical Laboratory Services	\$0
Outpatient X-ray Services	\$0
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	\$20
Diagnostic Radiology Service	\$20
Therapeutic Radiology Service	\$20
PREVENTIVE SERVICES (MEDICARE-COVERED)	
Cardiovascular Screenings	\$0
Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines)	\$0
Pap Smears and Pelvic Exams	\$0
Prostate Cancer Screening	\$0
Colorectal Cancer Screenings	\$0
Bone Mass Measurement (Bone Density)	\$0
Mammography	\$0
Diabetes - Self-Management Training	\$0
Medical Nutrition Therapy and Counseling	\$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	\$0
Smoking Cessation Visit	\$0
Abdominal Aortic Aneurysm (AAA) Screenings	\$0
Diabetes Screening	\$0
HIV Screening	\$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	\$0
Screening for Depression in Adults	\$0
Screening for Sexually Transmitted Infections	\$0
High Intensity Behavioral Counseling to Prevents STIs and Intensive Behavioral Therapy for Cardiovascular Disease	\$0

DESCRIPTION	IN NETWORK & OUT-OF-NETWORK
Screening and Counseling for Obesity	\$0
ADDITIONAL BENEFITS/PROGRAMS (Non Medicare-covered)	
Routine Podiatry	\$35
Routine Podiatry – Number of visits per year	6
Routine Eye Exam Refraction – every 12 months	\$0
Routine Hearing Exam for Hearing Aids – every 12 months	\$0
Hearing Aid Allowance --- includes Digital Hearing Aids	\$500 Every 3 years – In Network only with UnitedHealthcare Hearing
Annual Routine Physical Exam	\$0
Wigs Coverage Allowance - subject to plan guideline	\$300 maximum
Limited Dental – Coverage for Extractions of total bony impacted wisdom teeth; limited to specific service codes	Subject to \$350 Deductible \$1,350 OOP Maximum 50% Coinsurance
WELLNESS/CLINICAL PROGRAMS	
Fitness	Renew Active
Caregiver	Included
NurseLine	Included
Access Support	Included
Disease Management – Chronic Heart Failure (CHF)	Included
Disease Management – Coronary Artery Disease (CAD)/Diabetes	Included
Disease Management – End Stage Renal Disease (ESRD)	Included
Group Retiree Case Management	Included
Advanced Illness Care Management	Included
Hi Health Discount Program	Included
Housecalls Program	Included
<i>Note:</i> In the chart above, “Non-Medicare Covered” means that the service is not typically covered by Medicare, but if medically necessary will be covered under the MPS Group Medicare Advantage plan. “Medicare Covered” means both Medicare and MPS Group Medicare Advantage plan will typically cover the service if medically necessary.	
Outpatient Prescription Drug Coverage	
Rx Deductible	None
Part D Retail Co-pay (up to a 30 day supply)	
Tier 1: Generic	\$8
Tier 2: Preferred Brand	\$25
Tier 3: Non-Preferred Brand	\$50
Tier 4: Specialty Tier	\$50
Part D Preferred Mail Order Co-pay (up to a 90 day supply)	
Tier 1: Generic	\$16
Tier 2: Preferred Brand	\$50
Tier 3: Non-Preferred Brand	\$100
Tier 4: Specialty Tier	\$100
<i>Note:</i> Once a member’s true out-of-pocket costs reach \$2,100, they reach the catastrophic stage. Once in this stage, you won’t pay anything for your covered part D drugs for the remainder of the plan year. See the MPS Group Medicare Advantage Plan materials from UnitedHealthcare or, if you have questions on the catastrophic coverage stage, call UnitedHealthcare at 1-866-487-9303.	



UnitedHealthcare® HouseCalls

Take advantage of your plan benefits and schedule a HouseCalls visit. HouseCalls is a yearly in-home health and wellness visit that is available to you at no cost.



What does a HouseCalls visit include?

- Up to an hour of 1-on-1 time with a licensed health care practitioner
- A comprehensive exam
- Health care screenings tailored to you
- A medication review
- Education, prevention tips and referrals to health services, if needed



Why choose a HouseCalls visit?

- ✓ You can talk to a health care practitioner in the comfort of your own home
- ✓ It's another chance for you to ask questions and get answers about the things that matter most to you
- ✓ The health care practitioner will send a visit summary to you and your primary care provider (PCP) to keep you both informed



Schedule a visit today

Call us at **1-866-447-7868**, TTY **711**, Monday–Friday, 8 a.m.–8:30 p.m. ET.
Schedule online at uhchousecalls.com.



MILWAUKEE
PUBLIC SCHOOLS

**United
Healthcare®**
Group Medicare Advantage



HouseCalls

Common questions

What will happen in the visit?

The visit takes up to an hour. You'll get a health evaluation, including a physical exam and tailored health care screenings. The rest of the time is spent talking about health topics that are important to you.

Where should the visit take place?

It can be done sitting at your kitchen table, in the living room or wherever is comfortable for you.

How do I prepare for my visit?

Before your visit, we'll send you a reminder with tips on how to prepare. These include:

- Wear shoes that can be easily removed to have your feet checked
- Make a list of upcoming appointments with your PCP and specialists
- Gather your medications, including both prescription and over-the-counter, vitamins and supplements
- If you record blood pressure readings, please have your results available for review
- If you have diabetes, please have your blood glucose meter handy
- Make a list of questions and concerns you'd like to discuss

Also, the day before your visit, our health care practitioner may call you to introduce themselves and answer any questions about the visit.

I already see my provider regularly. Is this for me?

Think of a HouseCalls visit as an extra layer of care. It gives you valuable 1-on-1 time with a health care practitioner. Plus, we share details about your visit with your PCP.

HouseCalls may not be available with all plans or in all areas.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

UnitedHealthcare Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCION: si habla espanol, tiene a su disposicion servicios gratuitos de asistencia lingüística. Llame al número de teléfono gratuito para miembros que aparece en la tarjeta de ID.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請撥打您會員卡所列的免付費會員電話號碼

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**Have questions
about your
health
plan benefits?**

Visit
uhhousecalls.com

Or call the customer
service number on
your member ID card.

**United
Healthcare**
Group Medicare Advantage

Appendix C: 2026 Retiree Rates

All monthly rates effective January 1, 2026 – December 31, 2026.

Retiree Health Plan rates do not include vision insurance.

Total Monthly Premium (Health):			
All monthly rates effective January 1, 2026 – December 31, 2026			
HEALTH PLAN	PPO/Choice Plus	EPO Plan	HDHP
Single	\$1,184.74	\$1,226.20	\$1,121.23
Family	\$2,784.13	\$2,881.58	\$2,610.01
Couple, 1 w/ Medicare	\$1,399.74	\$1,441.20	\$1,336.23
Family, 1 w/ Medicare	\$1,814.39	\$1,870.37	\$1,703.78
Family, 2 w/ Medicare	\$844.66	\$859.17	\$797.56
Self-Pay Rates for Retirement Dates on/after 7/1/13			
Single	\$1,746.81	\$1,799.22	\$1,675.34
Family	\$3,493.63	\$3,598.44	\$3,350.68
Couple, 1 w/ Medicare	\$1,961.81	\$2,014.22	\$1,890.34
Family, 1 w/Medicare	\$2,465.23	\$2,535.25	\$2,343.41
Family, 2 w/ Medicare	\$933.41	\$951.03	\$883.07

Medicare Only Rates

The following rates apply for all retirees who have health insurance coverage and where all the individuals covered on the plan are Medicare eligible. Upon reaching Medicare eligibility, individuals will automatically be enrolled into the applicable Medicare Advantage program.

HEALTH PLAN	Medicare Advantage (including Self-Pay only)
Single w/ Medicare	\$215.00
Couple, 2 w/ Medicare	\$430.00
Family, 3 w/Medicare	\$645.00
Family, 4 w/Medicare	\$860.00

Note: Retiree premium contributions vary by the amount of the Board's share of the premium in effect at the time of retirement. Retirees not entitled to a Board-paid subsidy pay the entire premium.

For self-pay retirees paying the full amount of the premium with retirements on or after July 1, 2013, please refer to the above rate table entitled, "Self-Pay Rates for Retirement Dates on/after 7/1/13."

Appendix D: COBRA Coverage Rates

All rates effective January 1, 2026 – December 31, 2026

Health COBRA Rates:

COBRA Coverage Rates (Consolidated Omnibus Budget Reconciliation Act of 1985 Continuation Coverage) All rates effective January 1, 2026 – December 31, 2026			
HEALTH PLAN	PPO/Choice Plus	EPO Plan	HDHP
Active Employees Monthly COBRA Premium (includes Vision)			
Single	\$1,212.87	\$1,255.16	\$1,148.09
Family	\$2,850.57	\$2,949.97	\$2,672.97
Retiree Monthly COBRA Premium (excludes Vision)			
Single	\$1,208.43	\$1,250.72	\$1,143.65
Family	\$2,839.81	\$2,939.21	\$2,662.21
Couple, 1 w/ Medicare	\$1,427.73	\$1,470.02	\$1,362.95
Family, 1 w/ Medicare	\$1,850.68	\$1,907.78	\$1,737.86
Family, 2 w/ Medicare	\$861.55	\$876.35	\$813.51

COBRA Medicare Only Rates

HEALTH PLAN	Medicare Advantage
Single w/ Medicare	\$219.30
Couple, 2 w/ Medicare	\$438.60
Family, 3 w/Medicare	\$657.90
Family, 4 w/Medicare	\$877.20

