

# Milwaukee Retiree Firefighters and Police

Benefit Option for Retired Public Safety Officers - 2016



## MetLife



**Here's an overview of the benefit plans you are eligible to enroll in and details about the specific benefits and plans that are available.**

### How can this Dental Plan benefit you?

Keeping your teeth healthy can be one important step in maintaining overall health. Keeping up with your dental cleanings and other preventive care now can help you avoid expensive dental problems and costly treatments later on. And since more than 90% of all systemic diseases produce oral signs and symptoms, dentists can play an important role in screen for these serious health conditions so they can be addressed early on.<sup>1</sup> Other advantages include:

- Go to your dentist or one of the thousands in the network
- Discounts from 15-45% when you visit participating dentists<sup>2</sup>
- Protection against unexpected costs
- Tools that help you take charge and make informed decisions about your health.

### Why Vision Benefits?

Regular vision care is more than the first step to correcting vision problems or treating eye diseases. A routine eye exam may alert you to the onset of more serious health problems, like diabetes, even before a diagnosis is made by a general healthcare provider. Other advantages include:

Choice of eye care professionals

- Choice of Eyewear<sup>3</sup>
- Additional discounts on glasses and sunglasses
- Laser vision correction





Dear Retirees

Over the course of the last several years, both the Milwaukee Professional Fire Fighters Association Local 215 as well as the Milwaukee Police Association IUPA Local 21 AFL-CIO has worked diligently in achieving an additional benefit to you as a retired Public Safety Officer. It has long been recognized that, while our benefits in retirement are exceptional, one piece had been missing. We are very excited, that for the first time, we are able to offer a **Voluntary Group Dental and Vision** program to all of you. The plan design for this group product that cannot be purchased on the individual market or upcoming state exchanges and is exclusive to our members.

Enclosed, you will find literature that will explain the plan offerings and allow you to enroll for these crucial benefits. This is in conjunction with the "Open Enrollment" period for the health care benefits going into the 2014 calendar year. We have worked in partnership with an entity named "Source 1 Benefits." To further explain, Source 1 Benefits contracts with MetLife to achieve the Dental and Vision Benefit package that is available for your review in the enclosed materials. The designated help line for our group at Source 1 Benefits is 414-220-9900 if you have dental/vision enrollment questions.

Both Local 215 and the MPA have worked alongside the City of Milwaukee Employee Retirement System (CMERS) and the CMERS Pension board to achieve this objective. Currently, the only mechanisms for you to achieve these benefits are through your spouse's employment benefit package, to utilize the COBRA option through the City of Milwaukee, or to just simply pay out of pocket.

Enclosed you will find material that will explain why these benefits are important and how to enroll. This will be made available in conjunction with the "Open Enrollment" period for the health care benefits going into the 2014 calendar year and continue as an annual offering during this same period each October. Payment for these benefits will be automatically deducted from your monthly pension payments and more importantly, the cost will also be applicable towards the \$3,000 "HELPS" maximum annual for benefits paid, which is not the case if you pay out of pocket or utilize COBRA.

Easy and Convenient, now you can sign up two-ways: 1. over the phone at 414-220-9900 or 2. mail in the completed enrollment form and payroll deduction authorization directly to Source 1 Benefits with enclosed envelope.

Again, it is truly an honor to be able to afford these benefits to our retirees and annuitants that have never been available before to you. We certainly hope that this new option benefits all of you now and in the years to come.

Sincerely,

Dave Seager  
President  
Milwaukee Professional Fire Fighters Assn.  
IAFF Local 215

Mike Crivello  
President  
Milwaukee Police Association  
IUPA Local 21 AFL-CIO

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# Dental & Vision Benefits Summary



## MetLife

### Dental Network Plan (Option 1)

	In-Network	Out-of-Network
Basis of Reimbursement	Negotiated PDP fee	Negotiated
Type A – Preventive	100%	80%
Type B – Basic	80%	60%
Type C – Major	50%	40%
Individual Deductible (Annual) per person	\$50.00	\$50.00
Deductible Applies To	Type B & C	Type B & C
Calendar Year Maximum	\$1,200.00	\$1,200.00
Rates		
Retiree Only:	\$37.43	Rates are guaranteed for 1 year.
Retiree + One Dependent	\$74.87	
Retiree + Family	\$126.02	

### Dental Freedom Plan (Option 2)

	In-Network	Out-of-Network
Basis of Reimbursement	Negotiated PDP fee	80th Percentile R&C
Type A – Preventive	100%	100%
Type B – Basic	80%	80%
Type C – Major	50%	50%
Individual Deductible (Annual) per person	\$50.00	\$50.00
Deductible Applies To	Type B & C	Type B & C
Calendar Year Maximum	\$1,200.00	\$1,200.00
Rates		
Retiree Only	\$49.91	Rates are guaranteed for 1 year.
Retiree + One Dependent	\$99.82	
Retiree + Family	\$1168.45	

### Vision Plan

	Member Cost	Out-of-Network
Exam with Dilation as Necessary (Once Every 12 Months)	\$10 Copay	\$45
Standard Contact Lens Fit and Follow-Up	Up to \$60	Applied to Allowance
Premium Contact Lens Fit and Follow-Up	Up to \$60	Applied to Allowance
Frames (Once Every 24 Months)	\$25 Copay; \$130 Allowance	\$70
Standard Plastic Lenses (Once Every 12 Months)		
▪ Single Vision	\$25 Copay	\$30
▪ Bifocal	\$25 Copay	\$50
▪ Trifocal	\$25 Copay	\$65
▪ Standard Progressive Lens	\$25 Copay	\$50
▪ Premium Progressive Lens	\$	\$50
Contact Lenses (Once Every 12 Months)		
▪ Conventional	\$0 Copay; \$105 allowance, 15% off balance over \$105,	\$105
▪ Medically Necessary	\$0 Copay, Paid in Full	\$210
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Rates		
Retiree Only:	\$8.00	Rates are guaranteed for 4 years
Retiree + One Dependent	\$16.00	
Retiree + Family	\$23.00	

# Dental Network Plan (Option 1)

## (Comprehensive – Custom Lower Cost (Flex))

### Class Description: All Active Full Time Employees

#### TYPE A (Benefits are payable immediately from the start date of an individual's benefits)

Examinations	1 time in 6 months
Examinations – Problem Focused	Combined with Examinations Limit
Prophylaxis: Cleanings	1 time in 6 months
Fluoride	1 time in 12 months for a dependent child under age 14
Bitewing X-Rays	For a child under 14: 1 time in 1 calendar year Adult: 1 time in 1 calendar year
Labs & Other Tests	

#### TYPE B (Benefits are payable immediately from the start date of an individual's benefits)

Sealants	1 per molar in 60 months for a child under age 14
Space Maintainers	1 per lifetime for child under age 14
Full Mouth X-Rays	Once in 5 calendar years
Amalgam Fillings	1 replacement per surface in 24 Months
Periodontal Maintenance	2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb:2)
Scaling & Root Planing	1 per quadrant in any 24 month period
Emergency Palliative Treatment	
Periapical X-Rays	
Other X-Rays	
Resin Composite Fillings (excludes coverage for composite fillings on molars)	
Pulpotomy	
Pulp Capping	
Pulp Therapy	
Periodontics – Non-Surgical	
Oral Surgery: Simple Extractions	
General Services	

#### TYPE C (Benefits are payable immediately from the start date of an individual's benefits)

Consultations	1 in 12 months
Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 per quadrant in any 60 month period
Prefabricated Crowns	1 per tooth in 10 calendar years
Crown Buildups/Post Core	1 per tooth in 10 calendar years
Repairs	1 in 12 months
Recementations	1 in 12 months
Dentures	1 in 10 calendar years
Immediate Temporary Dentures – Complete/Partial	1 in 12 months
Dentures – Rebases/Relines	1 in 36 months
Denture Adjustments	1 in 12 months
Fixed Bridges	1 in 10 calendar years
Inlays/Onlays/Crowns	1 replacement per tooth in 10 calendar years
Implant Services	1 per tooth position in 10 calendar years
Implant Repairs	1 in 12 months
Implant Supported Prosthetic	1 per tooth in 10 calendar years
Tissue Conditioning	1 in 36 months
Occlusal Adjustments	1 in 12 months
General Anesthesia	
Apexification & Recalcification	
Periodontal Surgery – Soft and Connective Tissue Grafts	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

# Dental Freedom Plan (Option 2)

## (Comprehensive – Custom Lower Cost (Flex))

### Class Description: All Active Full Time Employees

#### TYPE A (Benefits are payable immediately from the start date of an individual's benefits)

Examinations	1 time in 6 months
Examinations – Problem Focused	Combined with Examinations Limit
Prophylaxis: Cleanings	1 time in 6 months
Fluoride	1 time in 12 months for a dependent child under age 14
Bitewing X-Rays	For a child under 14: 1 time in 1 calendar year Adult: 1 time in 1 calendar year
Labs & Other Tests	

#### TYPE B (Benefits are payable immediately from the start date of an individual's benefits)

Sealants	1 per molar in 60 months for a child under age 14
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Occlusal Adjustments	1 in 12 months
General Anesthesia	
Apexification & Recalcification	
Periodontal Surgery – Soft and Connective Tissue Grafts	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

## DENTAL EXCLUSIONS

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### All Active Full Time Employees

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
- Services for which a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan.
- This exclusion will apply whether or not the person receiving the services is enrolled for the government plan.
- We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the dentist on a separate basis – Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

# Vision PPO Schedule of Benefits

M130D-10/25

Benefit	In-Network Coverage	Out-of-Network Reimbursement	Frequency
<b>Eye Examination</b> (one per frequency) <ul style="list-style-type: none"> <li>Comprehensive exam of visual functions and prescription of corrective eyewear</li> </ul>	Covered after a \$10 copay	Covered up to \$45 allowance	12 months
<b>Materials/Eyewear</b> (Either glasses or contacts allowed per frequency)	\$25 copay	Not applicable	Not applicable
<b>Standard Corrective Lenses</b> <ul style="list-style-type: none"> <li>Single vision</li> <li>Lined bifocal</li> <li>Lined trifocal</li> <li>Lenticular</li> </ul>	Covered after eyewear copay	Covered up to: \$30 allowance \$50 allowance \$65 allowance \$100 allowance	12 months
<b>Standard Lens Options<sup>1</sup></b> <ul style="list-style-type: none"> <li>Ultraviolet coating</li> <li>Polycarbonate (child up to age 18)</li> </ul>	Covered after eyewear copay	Applied to the allowance for the applicable corrective lens	12 months
<b>Progressive</b> <ul style="list-style-type: none"> <li>Polycarbonate (adult)</li> <li>Scratch-resistant coating</li> <li>Tints</li> <li>Anti-reflective coating</li> <li>Photochromic</li> </ul>	These lens options are available with "not to exceed" pricing/maximum copay. <sup>1</sup>	\$50 allowance	
			Applied to the allowance for the applicable corrective lens
<b>Frame Allowance</b> (20% off the additional amount when patients choose a frame that exceeds the allowance. Available from all in-network providers, except Costco locations.) <ul style="list-style-type: none"> <li>Costco</li> </ul>	Covered up to: \$130 allowance after eyewear copay	Covered up to: \$70 allowance	24 months
	\$70 allowance after eyewear copay		
<b>Contact Lenses</b> <ul style="list-style-type: none"> <li>Contact Fitting and evaluation</li> <li>Elective lenses</li> <li>Necessary</li> </ul>	Standard or Premium fit covered in full with a copay not to exceed \$60.	Applied to the allowance for the contact lenses	12 months
	Covered up to \$130 allowance	Covered up to \$105 allowance	
	Covered after eyewear copay	Covered up to \$210 allowance	
<b>Value Added Features</b>			
<ul style="list-style-type: none"> <li>Additional Lens Options<sup>1</sup></li> </ul>	Average 20-25% savings on all other lens options.		
<ul style="list-style-type: none"> <li>Additional Discounts on Glasses and sunglasses</li> </ul>	20% discount off the cost for additional pairs of prescription glasses and non-prescription sunglasses, including lens options.		
<ul style="list-style-type: none"> <li>Laser Vision Correction</li> </ul>	Discounts averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Discounts only available from MetLife participating facilities.		

**WARNING: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.**

<sup>1</sup> All lens options are available at participating private practice provider offices, and not to exceed copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. At this time, all lens options and "not to exceed" copays and pricing are not available at Costco. Please contact your local Costco to confirm the availability of lens options and pricing prior to receiving services.

## THE SAVINGS YOU NEED, THE CHOICES YOU WANT

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**Choice of eye care professionals.** You can go to any licensed eye care professional. Or you can choose from any of the thousands of ophthalmologists, optometrists and opticians working out of private practices or at top optical retail chains, like Costco Optical, EyeMasters, Visionworks, and more. To locate a MetLife Vision provider, you may visit [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) and click on “Find a Vision Provider” or call 1-855-MET-EYE1 (1-855-638-3931) for access to our 24/7 Interactive Voice Response system.

For additional convenience, MetLife Vision has a service arrangement with Walmart that makes it easy for you to use your MetLife Vision benefits at Walmart and Sam’s Club locations. While these locations are considered out-of-network, MetLife Vision plans

include a generous reimbursement schedule for services obtained at out-of-network locations. And these locations have agreed to process MetLife plans — verify eligibility and submit claims — so there are no claim forms for you to submit.

**Choice in Eyewear.** You can choose the eyewear that is right for you and your budget from among a broad spectrum of eyewear options. From classic styles to the latest designer frames, you will find hundreds of options for you and your family. Choose from great brands, like FENDI, bebe®, Calvin Klein, Nike, Tommy Bahama® and Disney.

## VISION EXCLUSIONS AND LIMITATIONS OF BENEFITS

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### **This plan does not cover the following services, treatments and materials:**

- Services and/or materials not specifically included in the Schedule of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye.
- Prescription and non-prescription medications.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing and cleaning.
- Any eye examination or any corrective eyewear required as a condition of employment.
- Services and supplies received by You or Your Dependent before the Vision Insurance starts for that person.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person’s regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers’ Compensation Law, Employer’s Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program or coverage provided by a government as an employer or Medicare.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.



## FREQUENTLY ASKED QUESTIONS

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### **When does the application and payroll authorization have to be returned?**

These forms need to be sent into Source 1 Benefits prior to the 10th of the month for an effective start of coverage on the 1st of the following month.

### **What will it cost me to participate in dental and/or vision plans being offered?**

Please refer to the enclosed plan/benefit summary for additional information. If after reviewing you have any questions you can contact Source 1 Benefits at 414-220-9900.

### **What do I need to do if I want to enroll or make changes to my dental and/or vision coverage?**

You will need to complete the enclosed application and payroll deduction authorization and return to Source 1 Benefits either fax 312-454-6025 or mail Source 1 Benefits, 206 South Jefferson, 2nd Floor, Chicago, IL 60661.

### **How can I find what providers are in the MetLife dental and vision network?**

There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists by calling 1-800-Get-Met8 to have a list faxed or mailed to you. A list of these providers can also be found at [www.metlife.com/dental](http://www.metlife.com/dental). Source 1 Benefits will also be able to assist you by calling 414-220-9900.

### **What if my provider is not in the network?**

You are always free to select the provider of your choice. However, if you choose a provider who does not participate in the network, your out-of-pocket expenses will be more, since you will be responsible for any difference between the provider's fees and your plans payment. If you are not going to an in-network dental provider you may want to consider enrolling on the dental high option plan (Freedom Plan) since the out-of-network reimbursement is higher than the low option (Network Plan).

### **What if I have questions on the plans being offered?**

You can contact Source 1 Benefits at 414-220-9900.

**CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM  
NOTICE TO INSURED**

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.

To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:

Metropolitan Life Insurance Company  
PO Box 14587  
Lexington, KY 40512

Please indicate to whom and where the translated document is to be sent.

**Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.

Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:

Metropolitan Life Insurance Company  
PO Box 14587  
Lexington, KY 40512

Por favor, indique a quién y a dónde debe enviarse el documento traducido.

NOMBRE \_\_\_\_\_

DIRECCIÓN \_\_\_\_\_

**免費語言服務。** 您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。為收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：

Metropolitan Life Insurance Company  
PO Box 14587  
Lexington, KY 40512

請指明經翻譯文件收件人的姓名及地址。

姓名 \_\_\_\_\_

地址 \_\_\_\_\_

**Անվճար թարգմանական ծառայություններ:** Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆոռնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

**សេវាកម្រៃដោយឥតគិតថ្លៃ ។** អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងពាណិជ្ជកម្ម (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

**Kev pab txhais lus tsis kom them nqi.** Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus Iv-saws-las ntawm 1-800-927-4357.

**無料の通訳サービス。** 通訳を通して日本語で文書を読み上げることができます。サービスの利用をご希望の方は、お手持ちのIDカードに記載されている番号、または1-800-942-0854へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁1-800-927-4357までお問い合わせください。

**무료 통역 서비스.** 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

**Бесплатные услуги устного перевода.** Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

**Libreng serbisyo sa pagsasalín.** Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

**Dịch vụ thông dịch miễn phí.** Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

**لا تتوفر خدمات ترجمة بتكلفة.** يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357. **سرویس های ترجمه رایگان.** شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی، از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید. **Бла معاوضه مترجم دی خدمات مل سکدی اے۔** تسی ایک مترجم دی خدمات حاصل کریسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈسکدا اے۔ مدد واسطے ایڑیں آئی ڈی کارڈ، کربوتو، دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال کال کرو۔

**CA LAP STANDALONE NOTICE**

**(09/08)**

## UNIVERSAL ENROLLMENT FORM

Please compete and fax or mail to:  
 Source 1 Benefits, 206 South Jefferson Street – Suite 200, Chicago, IL 60661  
 (312) 454-6025 Fax

Group Information:			
Group Name: <b>Milwaukee Public Safety Retirees</b>		Coverage Effective Date:	
Address: <b>5625 West Wisconsin Avenue</b>	City: <b>Milwaukee</b>	State: <b>WI</b>	Zip: <b>53213</b>

Applicant Information:			
Last Name	First Name	M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Reason for Enrollment: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Coverage
Residence Mailing Address (Number, Street, Apartment)		City	State    Zip
Home Telephone (    )		Email Address	

Dental & Vision Benefit Elections (Choose one option for Dental and Vision)		
<b>Dental — MetLife (Network Plan)</b> <input type="checkbox"/> Applicant Only — (\$37.43 per month) <input type="checkbox"/> Applicant & 1 Dependent — (\$74.87 per month) <input type="checkbox"/> Applicant & Family — (\$126.02 per month) <input type="checkbox"/> I decline all Dental benefits	<b>Dental — MetLife (Freedom Plan)</b> <input type="checkbox"/> Applicant Only — (\$49.91 per month) <input type="checkbox"/> Applicant & 1 Dependent - (\$99.82 per month) <input type="checkbox"/> Applicant & Family — (\$168.45 per month) <input type="checkbox"/> I decline all Dental benefits	<b>Vision — MetLife</b> <input type="checkbox"/> Applicant Only — (\$8.00 per month) <input type="checkbox"/> Applicant & 1 Dependent — (\$16.00 per month) <input type="checkbox"/> Applicant & Family — (\$23.00 per month) <input type="checkbox"/> I decline all Vision benefits

Dependent Information for Dental and Vision coverage: (Dependent information must be completed if choosing coverage for dependents.)								
First Name	Last Name	Relationship Daughter (D) or Son (S)	SEX		Date of Birth (MM-DD-YY)	Social Security Number	Are you selecting dental coverage for this dependent?	Are you selecting vision coverage for this dependent?
			M	F				
		<b>Spouse</b>						

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

### SIGNATURE SECTION:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize CMERS to reduce my check in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in Spouse & Child(ren) status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

**X** \_\_\_\_\_ Date \_\_\_\_\_  
 Member Signature

## Fraud Warnings

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**New York** (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon and Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Pennsylvania and all other states:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1  
FW

## Declarations and Signature

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.



_____ Signature of Employee	_____ Print Name	_____ Date Signed (MM/DD/YYYY)
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GEF09-1  
DEC



## Retired Public Safety Officer Authorization for Insurance Premium Deduction from Pension Payment

Person ID \_\_\_\_\_  
or SSN: \_\_\_\_\_

Member Name: \_\_\_\_\_

### Member Authorization

I hereby elect to have amounts deducted from my ERS benefit to pay for qualified insurance premiums (as provided by the Pension Protection Act of 2006) as administered by the Insurance Provider or Third Party Administrator (TPA) (hereinafter "Vendor") named below.

By signing this authorization, I agree to and understand that:

1. I am voluntarily signing up for this deduction;
2. I have read and understand the Retired Public Safety Officer Insurance Premium Deduction Program information;
3. I certify that I am a retired public safety officer, as defined by federal law;
4. The ERS is not responsible for any erroneous deductions that occur during my participation in this program;
5. The ERS is not responsible for the insurance or any associated claims, disputes, late fees, lapsed coverage, lapsed premium payments, and/or other actions related to the insurance and/or deductions;
6. The ERS is not responsible for any refunds and/or retroactive deductions that may need to occur;
7. Once funds are transferred to the Vendor, any adjustments to the deductions (e.g. refunds, insufficient deductions, etc.) will be between the Vendor and me, and will not be the responsibility of the ERS;
8. The ERS is only acting as the pay administrator for the purposes of routing the deductions from my pay check to the Vendor;
9. The ERS is not responsible for the application of the funds to my insurance account;
10. The ERS will be informed of the deduction amount to be remitted to the Vendor no later than the 10<sup>th</sup> of each month for deductions to be taken from that month's payment, failing which deductions may not be taken from that payment (and the responsibility to pay the Vendor directly will reside with me);
11. Deductions cannot exceed my monthly annuity payment after all other deductions are taken, including federal and state income tax withholding, that no partial deductions will be taken and that they will reduce my net annuity payment;
12. Deductions will continue to be made from my pension payment until a) the ERS receives directions from me to stop, b) the Vendor does not inform the ERS of any deductions that need to occur, or c) if my benefit ceases;
13. Deductions will only be taken from monthly annuity payments (not from one-time and/or lump sum payments);
14. Deductions will be taken on a post-tax basis (the amount of the deduction will not affect the taxability of my regular benefit payment);
15. The Vendor may at any time inform the ERS of a change to the deduction amount, and the ERS will deduct the new amount from my pension payment if the funds are available;
16. The ERS will not inform me of any changes to the deduction amount;
17. The ERS will not inform me of any deductions that were not taken due to the unavailability of funds;
18. The ERS will not send a separate statement informing me of the total deductions withheld during the course of the year (this amount will be available on the payment advice);
19. This authorization will be effective the later of the first payroll period after receipt of this form by the ERS or the date listed below.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

### WAIVER OF CLAIMS

By signing this form, I agree that I will not make any legal claim of any kind against the ERS, its Board, staff and advisors, and the employer should my participation in this program result in unexpected tax liability to me, including interest and penalties. I understand that my ability to participate in this program is a valuable benefit for which I am willing to sign this waiver of all claims. I further release the ERS, its Board, staff and advisors, and the employer from any liability arising from the administration of payments to any insurer.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

**IMPORTANT LEGAL NOTICE**

THE IRS HAS NOT PROVIDED GUIDANCE TO DATE ON THE APPLICATION OF THIS PROGRAM. AS A CONDITION OF PARTICIPATION IN THIS PROGRAM, THE MEMBER ACCEPTS ALL RESPONSIBILITY FOR TRUTH OF THE INFORMATION PROVIDED TO THE ERS. IN ADDITION, IN CONSIDERATION OF PARTICIPATION, THE MEMBER AGREES THAT THE ERS, ITS BOARD, STAFF OR ADVISORS, AND THE EMPLOYER HAVE NO LIABILITY FOR ANY ADDITIONAL TAX LIABILITY, INCLUDING INTEREST AND PENALTIES THAT MAY ARISE FROM PARTICIPATION.

AS THIS WAIVER INVOLVES YOUR LEGAL RIGHTS, YOU ARE ADVISED TO SEEK COMPETENT LEGAL ADVICE PRIOR TO PARTICIPATING IN THE PROGRAM

I UNDERSTAND AND AGREE THAT I HAVE HAD A FULL OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND TO SEEK OUTSIDE ADVICE.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

**Vendor Information and Certification**

Insurance Provider: Metlife

TPA Name (if applicable) Source 1 Benefits

Insurance Provider/TPA (circle one)  
Representative Name & Title: Jack Byrnes VP

By signing this authorization, I certify that:

1. I am an authorized representative of the Vendor named above;
2. The member named in this release is a client of this Vendor;
3. I hereby agree to abide by the Insurance Provider Terms and Conditions of the Retired Public Safety Officer Insurance Premium Deduction Program;
4. The Vendor named in this release has a valid contract with the ERS to allow for such direct deductions for purposes of insurance under the HELPS Act and the member is eligible for such deductions



Vendor Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

**Retired Public Safety Officer Insurance Premium Deduction Program**

The Pension Protection Act of 2006 (PPA) allow certain ERS eligible retired public safety officers to take a tax deduction of up to \$3,000 on their federal income tax return for health and long-term care insurance premiums. This law is also commonly referred to as the "HELPS" Act (**H**ealth **C**are **E**nhancement for **L**ocal **P**ublic **S**afety Officers). The health or long-term care insurance can include coverage for an eligible participant's spouse and dependents (but note, the deduction is available only to eligible participants).

To take advantage of this deduction, the ERS must pay the premium to the eligible participant's insurance provider directly.

The eligibility is determined by the Federal law. "Public safety officer" is defined in 26 USC 402(l)(4)(C). At this time only the following classes of ERS annuitants can participate in the program:

- Fire and Police Service Retirees
- Fire and Police Disability Retirees

Other retirement types, and survivors, are not eligible to participate in this program at this time.

More detailed information about the public safety officer tax exclusion and eligibility to participate can be obtained from the Internal Revenue Service's (IRS) ([www.irs.gov](http://www.irs.gov)).