City of Des Plaines

2023 Benefits Guide

DES PLAINES
ILLINOIS

FULL-TIME EMPLOYEES

Community & Economic Development

Public Works & Engineering

City Manager's Office

Finance

Police

Fire

What's new?

NEW! SUPPLEMENTAL LIFE INSURANCE CHANGES

EMPLOYE SUPPLEMENTAL LIFE

Beginning in 2023, the Employee Supplemental Life Insurance coverage election structure will change from a multiple of salary (1x, 2x, 3x or 4x) to a fixed amount of coverage elected in multiples of $10,000.

- If you are currently enrolled in Employee Supplemental Life Insurance, your coverage amount will be converted to a fixed value. This will be calculated by multiplying your salary (inclusive of base, longevity and special pays) as of October 1, 2022 by your multiple of salary coverage elected and then rounding this value to the next highest $10,000 in coverage (capped at a maximum of $500,000).
  - EXAMPLE:

Employee Salary as of 10/1/2022	x	Multiple of Salary Election as of 10/1/2022	=	TOTAL
$60,253		3x Salary		$180,759

Rounded Up = $190,000 In Coverage for 2023 Forward

- Employees currently enrolled in employee supplement life insurance received an email the week of 10/10/2022 confirming this coverage calculation.
- If you would like to increase your coverage amount or elect new coverage, you can elect a new coverage value during Open Enrollment. Please note, you must complete an evidence of insurability questionnaire and receive underwriting approval from the City's life insurance vendor before the new coverage amount takes effect.
- Also note, you can increase your coverage amount within 30 days of a Qualifying Event (i.e. marriage, child birth). No medical questionnaire or vendor approval is required for coverage below the employee $300,000 guaranteed issue amount, spousal $50,000 guaranteed issue amount and/or family plan coverage if the employee/spouse was not previously declined coverage from a previous medical underwriting review.

INCREASED COVERAGE MAXIMUMS FOR EMPLOYEE AND SPOUSE SUPPLEMENTAL LIFE

- The Employee Supplemental Life Insurance coverage maximum will increase from $500,000 to $750,000.
- The Spouse Supplemental Life Insurance coverage maximum will increase from $300,000 to $500,000.

**Medical underwriting approval will continue to be required for increased coverage elections that take place outside of new hire enrollment and qualifying events.*

NEW LIFE INSURNACE VENDOR

- Beginning January 1, 2023, the City's new Life Insurance vendor will be Securian Financial.
- Employee and Spouse Supplemental Life Insurance age band rates and Family Plan rates will remain the same for 2023.

securian FINANCIAL

Click here to return to Table of Contents

Table of Contents

Click here to return to Table of Contents

2023 Open Enrollment Instructions

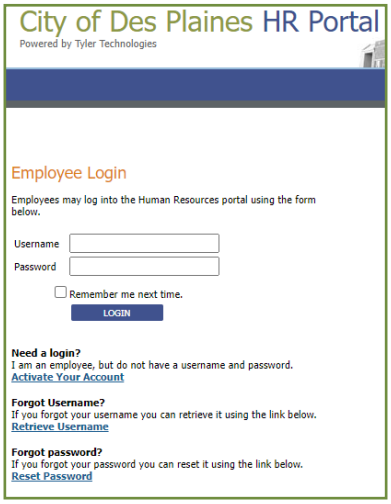
2023 Benefit Open Enrollment Via eSuite | Instructions

Open Enrollment: Monday, October 17 - Friday, October 28, 2022

Benefits enrollment will be completed online through eSuite.

- Employees making changes to their benefit elections –OR- enrolling in flexible spending accounts and/or transit benefits MUST complete their 2023 enrollment online through eSuite.
- If you do not complete your enrollment through the portal, your 2022 benefit elections will be carried over into 2023, with the exception of medical/dependent care flexible spending accounts (FSA) and transit benefits.
- If you wish to enroll in medical/dependent care FSAs and/or transit benefits for 2023, you MUST complete the your 2023 benefit elections through eSuite.
- Even if you are not planning on changing your benefits, you are highly encouraged to enroll in benefits using eSuite to ensure accurate enrollment in all benefits.
- Drop-in office hours will be made available for anyone who would like assistance with their benefit enrollment. Contact HR at hr@desplaines.org or call 847.391.5486 to schedule time.

Step 1 | Log Into Your eSuite Account

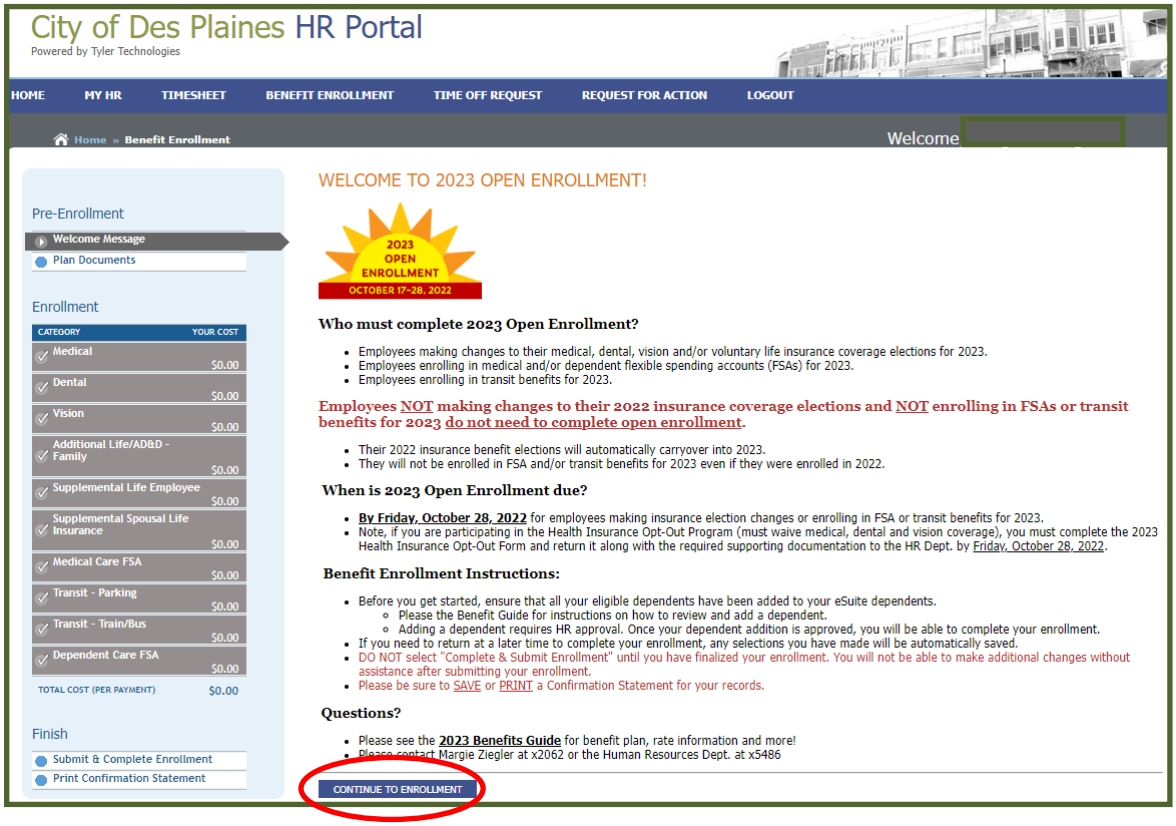


If you've never logged in or forgot your username or password, please use the handy links located at the bottom of the eSuite Employee Login page.

Step 2 | Select Benefit Enrollment and then Open Enrollment

Click here to return to Table of Contents

Step 3 | Begin your Benefit Enrollment



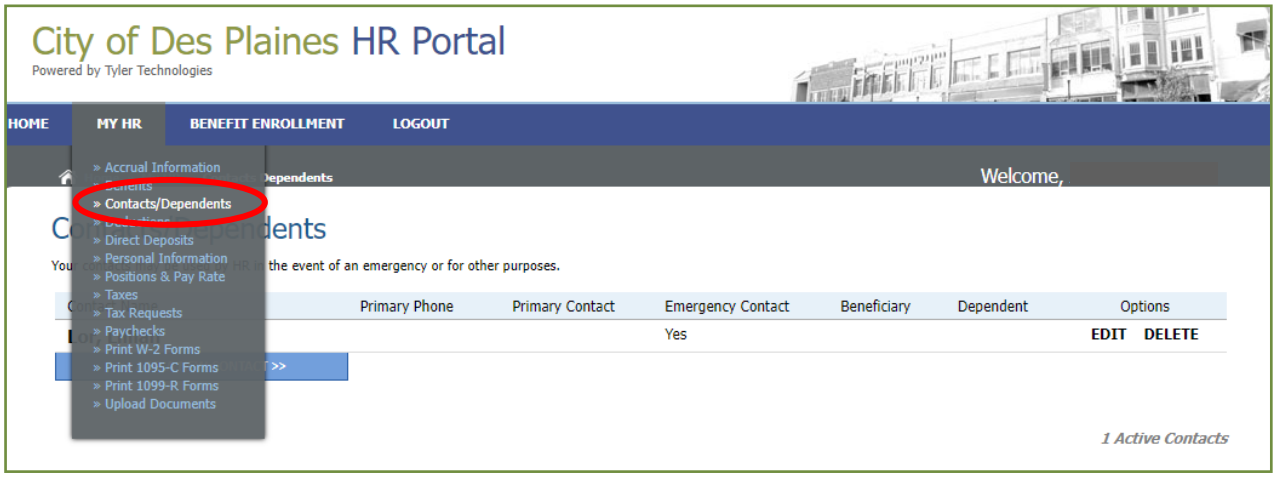
- Please read the Welcome Message and then click the “Continue Enrollment” button to begin your enrollment.
- The system will walk you through each benefit category.
    - Please read the benefit screen instructions and select a benefit option and coverage tier if applicable (Single, Family or Single +1) -OR- select “I would like to decline coverage” if waiving coverage for the benefit category.
        - NOTE: If you are switching to the HMO plan, you will need to provide HR with your three-digit Medical Group number(s) for yourself and any of your eligible dependents you are covering.
        - NOTE: The system will list your current coverage election for all benefit categories with the exception of flexible spending accounts and transit benefits. If enrolling in these benefits, you will need to enter an annual contribution amount.
    - Click the “Save and Continue” button to move on to dependent selection. Select the dependents to be covered under this benefit and then click the “Save and Continue” button to move on to the next benefit category.
- If you need to go back and make a changes to your benefit elections, simply click on the benefit category on the left-side benefit menu and you will be returned that that category’s election options.
- When you have completed your enrollment, select “Submit & Complete Enrollment” on the left-side menu. Carefully review your elections before hitting the “Submit” button.
    - PLEASE NOTE: You cannot make changes to your benefit elections after selecting the “Submit” button. If you need to make changes after selecting “Submit”, please contact the HR Dept.
- After submitting your enrollment elections, please be sure to select “Print Confirmation Statement” to print or save a confirmation of your benefit elections for your records.

Click here to return to Table of Contents

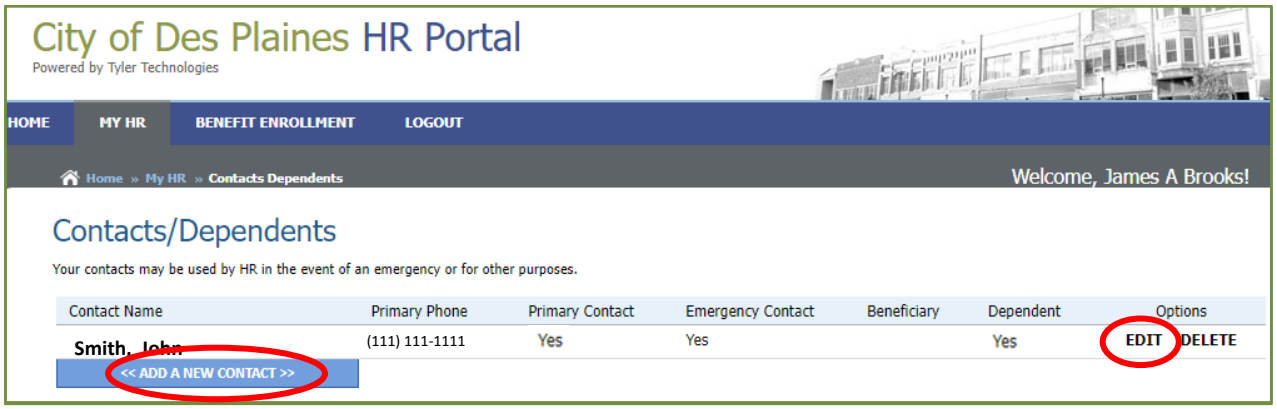
2023 Open Enrollment Instructions

Adding a Dependent or Updating Dependent Information in eSuite HR Portal

- Please select "Contacts/Dependents" under the MY HR menu.



- Next, select "Edit" to edit an existing dependent's information or click the "Add a New Contact" button to add a new dependent.



- Please be sure to fill-in the dependent first name, last name, relationship, date of birth, social security number and gender as well as check the same address as employee and dependent boxes.
    - Once your update request is approved by Human Resources, that dependent will be available to you for Open Enrollment in eSuite.
- NOTE: You can also designate the dependent as you Primary Contact or Emergency Contact by selecting the applicable boxes and filling in the contact information.
- NOTE: You cannot designate a beneficiary here. Please see page 7 for information regarding updating beneficiaries.
- Eligible dependents include spouses and children/step children under the age of 26 as well as adult children with physical or mental incapacity that occurred prior to the age of 26.
- Proof of dependency documentation is required for new dependent enrollments.

Click here to return to Table of Contents

Proof of Dependency Required for New Dependent Enrollments

If you are enrolling a dependent for the first time in City coverage, you must provide dependent eligibility documentation, generally a marriage or birth certificate (or crib card for a newborn).

- Please see page 24 for a full list of acceptable documents.

Qualifying Life Events for Mid-Year Benefit Changes
- - 30 Day Window to Make Benefit Changes - -

Changes to your benefits can be made outside of open enrollment period for qualified and documented life events.

- Your benefits change must be consistent with your life event/status change.
- REMEMBER: Your coverage change request and supporting documentation must be submitted to Human Resources within 30 days of the qualifying event. (i.e. marriage, date of birth). Email hr@deplaines.org to learn more about the process.
- Please see page 24 for additional information.

Keep Your Beneficiaries Up-To-Date | Life Insurance, Retirement Savings Plans, Pensions

You can update your beneficiaries at any time.

- For City-paid and supplemental life insurance, please complete The Standard Beneficiary Designation Change Form and return the form to Human Resources.
    - Beginning January 1, 2023, employees will use the Securian Beneficiary Designation Change Form.
- For Mission Square (formerly ICMA-RC) or Nationwide retirement savings plans, please visit your online member portal.
    - Mission Square
    - Nationwide
- For IMRF pension and death benefits, please visit your online member portal.
- For Fire and Police pensions, please see your pension representative to update your eligible beneficiaries upon marriage, divorce or child birth/adoption.

Retirement Savings | Start, Stop or Change Contributions at Anytime

You can start, stop or make changes to your retirement savings plan contributions at any time.

- Visit Mission Square to enroll or make changes to your 457 Plan and/or Roth IRA.
- Visit Nationwide to enroll or make changes to your 457 Plan.
- For IMRF Voluntary Additional Contributions, complete the VAC form and forward the form to Human Resources for processing.

Click here to return to Table of Contents

Medical Insurance

BCBS OF ILLINOIS | CONTACT INFO AND USEFUL LINKS

PPO | 877.245.5681 HMO | 800.892.2803

BCBSIL Website | Blue Access for Members | Mobile App | Provider Finder

BlueCross BlueShield of Illinois

2023 Medical Plan Options and Employee Contributions

Major Medical Coverage	Blue Cross Blue Shield of Illinois PPO Option 2 – P14326	Blue Cross Blue Shield of Illinois PPO Option 3 – P14330	Blue Cross Blue Shield of Illinois HMO Option 1 – H15040
Lifetime Maximum	Unlimited	Unlimited	N/A
Coinsurance			
Network	80%, after deductible	90%, after deductible	100%
Non-Network	60%, after deductible	N/A	N/A
Deductible			
Network	$500 individual / $1,500 family	$300 individual / $900 family	N/A
Non-Network	$1,500 individual / $4,500 family	N/A	
Out-of-Pocket (includes deductible)			
Network	$2,000 individual / $6,000 family	$2,300 individual / $6,900 family	$1,500 individual / $3,000 family
Non-Network	$6,000 individual / $18,000 family	N/A	N/A
Office Visit (primary or specialist)			
Network	Deductible applies, then 80%	Deductible applies, then 90%	$10 primary / $10 specialist
Non-Network	Deductible applies, then 60%	N/A	No coverage
Inpatient and Outpatient Services			
Network	Deductible applies, then 80%	Deductible applies, then 90%	100%
Non-Network	Deductible applies, then 60%	N/A	No coverage
Hospital Emergency Care			
Network	$150 copay, waived if admitted	100%	$50 copay, then 100%
Non-Network			
Preventive Services			
Network	100%	100%	100%
Non-Network	Deductible applies, then 60%	N/A	No coverage
Vision Coverage			
Annual Vision Exam	N/A	N/A	*100% with EyeMed Provider
Annual Vision Materials	N/A	N/A	35% off retail frame price, lenses $50 - $135 w/ EyeMed Provider (see HMO Vision Care Program highlight sheet for details)
Prescription Drug	Administered by Express Scripts	Administered by Express Scripts	Administered by Express Scripts
Retail (30-day supply)	$15 generic / $25 brand name formulary / $45 brand name non-formulary	$15 generic / $25 brand name formulary / $45 brand name non-formulary	$10 generic / $15 brand name formulary / $30 brand name non-formulary
Mail Order (90-day supply) via ESI mail order, CVS/Walgreens retail	$20 generic / $35 brand name formulary / $50 brand name non-formulary	$20 generic / $35 brand name formulary / $50 brand name non-formulary	$10 generic / $15 brand name formulary / $30 brand name non-formulary
Prescription Drug Out-of-Pocket Maximum (Network)	$5,150 individual / $8,300 family	$4,850 individual / $7,400 family	$5,650 individual / $11,300 family
Employee Contributions (Semi-Monthly)			
Single	$28.28	$27.52	$23.65
Single + 1	$55.02	$53.47	$48.22
Family	$79.34	$78.83	$69.79

*Fees Apply for Premium Contact Lens Exams

This benefit schedule is for illustrative purposes only.

This exhibit in no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the plan.

Click here to return to Table of Contents

HMO vs. PPO Plans | The Basics

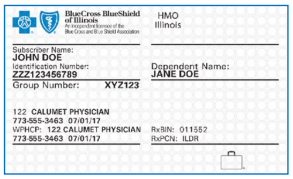
HMO Plans

- Typically, HMOs have lower monthly premiums.
- You can also expect to pay less out of pocket
- HMO care networks are generally smaller.
- Your healthcare services are coordinated by your designated Primary Care Physician (PCP) or Medical Group (MG).
- You must obtain referrals from your PCP/MG to access care from in-network specialists outside your MG.
- There are no deductibles. You make a co-payment for each treatment or doctor's visit.

PPO Plans

- PPOs tend to have higher monthly premiums in exchange for more flexibility and larger care networks.
- PPO plans do not require a designated Primary Care Physician or Medical Group for referrals to specialist care.
- You pay an annual deductible and benefits apply after the deductible amount has been met.
- Some PPOs, like the City's PPO2 Plan, offer non-network coverage though this coverage can be significantly more expensive than network coverage.

Open Enrollment & ID Cards | BCBS will mail new ID cards if you enroll in a new plan this year.



- HMO | Each dependent will receive a card listing their name, medical group and phone number. If you are switching to the HMO plan, you will need to provide HR with three-digit medical group number(s) for you and your enrolled dependents (if applicable).
- PPO | Employees with families will receive ID cards that show the employee's name only.
- If you do not change plans, you will not receive new cards.

Blue Access for Members (BAM) | Blue Access for Members is a secure online portal where you can manage your health coverage. Get claims information, explanation of benefit statements, information about BCBS programs and services, print temporary ID cards and learn more about how your health insurance benefits work.

- To sign up, visit bcbsil.com or download the mobile app from your app store.

Provider Finder | Search online for BCBSIL doctors, hospitals, medical groups and other health care providers using Provider Finder. If you are searching for an HMO provider/medical group number, please select "HMO Illinois" as the plan/network.

Blue 365 Member Discount Program | Gain access to health and wellness-related deals on fitness products, gym memberships, healthy eating and more. Visit Blue 365 for more information.

Well on Target | Well on Target is a program that is designed to give you the support you need to make healthy choices. With Well on Target you have access to a convenient, secure website with personalized tools and resources.

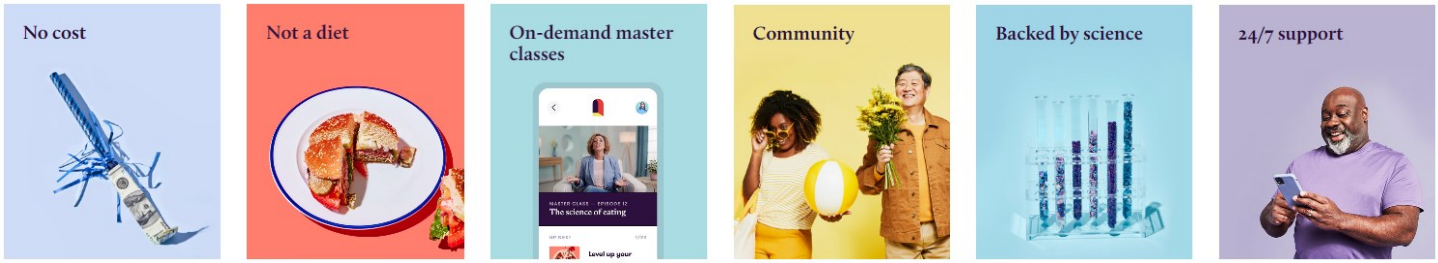
Click here to return to Table of Contents

Medical Insurance

Fitness Program | One Membership, Countless Options!

Fitness Program gives you unlimited access to thousands of participating gyms, on-demand workouts and live virtual classes. The cost varies per month depending on the gym package you choose, plus applicable taxes. That means you can use gyms and access virtual workouts wherever you are at home, near work or while traveling.

Wondr Weight Loss Program | Wondr is a clinically-proven program to help participants lose weight, sleep better, stress less, and so much more. Participants will learn simple skills based on behavioral science, helping them enjoy their favorite foods and feel better. Employees, spouses, and adult dependents enrolled in the City's BCBSIL medical plan are eligible to apply.



HMO Plan Only Benefits

HMO Vision Care Program (HMO Plan Only) | Benefits for covered members include:

- Coverage for one eye examination every 12 months with an EyeMed provider.
- Coverage for one standard contact lens evaluation and fitting every 12 months, when performed on the same day as your eye examination with an EyeMed provider. (Note, fees apply for premium contact lens exams.)
- Discount program providing 35% off retail frame price and $50-$135 off lenes with an EyeMed provider.

You don't need a referral. Simply visit any EyeMed provider and show your BCBSIL HMO ID card to access your vison care benefits and discounts. For more details about what your plan coverage, please visit www.eyemedvisioncare.com/bcbsil or call EyeMed at 844.684.2254.

NOTE: These HMO vision benefits and discounts and VSP vision benefits (if enrolled) cannot be combined to be used on the same exam or frame/lens purchase. Only one of these vision plans may be used on each individual exam or frame/lens purchase.

Out-of-Area Benefits (HMO Plan Only) | You can access health care benefits when you travel or temporarily live out of state.

- GUEST MEMBERSHIP | If you are out of the BCBSIL HMO service area for at least 90 consecutive days, you can apply to become a guest member of a participating BCBSIL HMO plan. You must remain a permanent resident within your HMO service area to be eligible for a guest membership. Please call the Customer Service on the back for your member ID card for details.
- BLUECARD | If you are traveling outside of Illinois for short periods of time (less than 90 consecutive days) and you need urgent or emergency care, you can use the BlueCard program. In an emergency, go directly to the nearest hospital or call 911. You will pay the applicable copay and will not have to submit claims, in most instances.

Click here to return to Table of Contents

PPO PLAN ONLY BENEFITS

HEALTH ADVOCATE (PPO PLANS ONLY) | PPO Plan members have access to a health advocate at no added cost. Health advocates work with you, and with your care providers on your behalf, to remove barriers and hassles that interfere with care. Get personal assistance with your health care matters.

- Understand your health benefits
- Talk to your BCBSIL clinician about health questions
- Sort out a new diagnosis and what to do next
- Shop for quality, lower-cost health care
- Earn cash rewards for making smart health care choices

Health advocates are available 24 hours a day, 7 days a week. Just dial the number on the back of your Blue Cross and Blue Shield of Illinois (BCBSIL) member ID card.

MEMBER REWARDS (PPO PLANS ONLY) | Same Procedure, Different Cost and Potential Cash in Your Pocket!

Member Rewards offers cash rewards when a lower-cost, quality provider is selected from several options.

How Does It Work?

- When a doctor recommends treatment, call a Benefits Value Advisor at the number on the back of your member ID card, or log into Blue Access for Members and click the Doctors and Hospitals tab – then on Find a Doctor or Hospital
- Choose a Member Rewards eligible location, and you may earn a cash reward
- Complete your procedure and, once verified, you will receive a check within 4 to 6 weeks

Questions? Call the number on the back of your member ID card.

VIRTUAL VISITS (PPO PLANS ONLY) | Virtual visits, by MDLIVE, provides a live consultation with an independently contracted board-certified MDLIVE doctor or therapist. Your visit can happen 24 hours a day, seven days a week by mobile app, online video or phone.

Instead of going to the office, you can have a virtual visit while at home, work or many other places. And a virtual visit may cost less than going to the urgent care clinic or emergency room. Connection options include:

- Online via Blue Access for Members or the MID Live website
- Download the MDLIVE mobile app from your app store
- Call MDLIVE at 888.676.4204
- Applicable deductible and co-insurance apply.

24/7 NURSE LINE (PPO PLANS ONLY) | The 24/7 Nurse Line can help you determine if you should call your doctor, go to the ER or treat the problem yourself. Access a registered nurse at 800.299.0274.

HINGE VIRTUAL PHYSICAL THERAPY (PPO PLANS ONLY) | See flyer for details.

LIVONGO DIABETES MANAGEMENT (PPO PLANS ONLY) | See flyer for details.

OMADA CHRONIC MANAGEMENT (PPO PLANS ONLY) | See flyer for details.

Click here to return to Table of Contents

Express Scripts Prescriptions

EXPRESS SCRIPTS | CONTACT INFO AND USEFUL LINKS

800.294.7041 Express Scripts Website Mobile App

Express Scripts manages the City's prescription drug benefit. Retail and mail-order prescription services for the City's medical programs are administered through Express Scripts.

- You are automatically enrolled in Express Scripts prescription drug coverage when you enroll in your Blue Cross Blue Shield health insurance plan.
- If you are enrolling for the first time or re-enrolling, you will receive a separate Express Scripts prescription drug card to use at the pharmacy when you fill prescriptions.

Member Account

Register for an Express Scripts account online at expressscripts.com to order refills, check order status, compare medication costs, find potential lower-cost options, receive time-sensitive alerts and reminders, print forms and much more.

Smart90 Program

If you take maintenance medications (long-term medications), be sure to obtain a 90-day/3-month supply from Walgreens, CVS or through Express Scripts home delivery to avoid paying the full cost of the prescription.

- Your newly prescribed maintenance medication will be given two 30-day courtesy fills.
    - NOTE: You will pay 100% of the prescription cost for each subsequent fill if not prescribed as a 90-day supply and filled via Mail Order, Walgreen's or CVS.
- Call Express Scripts or visit your Express Scripts member account for more information.

Utilize the Smart90 Program to avoid paying the full cost for maintenance medications.

Dispense as Written Rx Provision

- If you are taking a brand name prescription, with a generic alternative available, your physician must write "Dispense as Written" on your prescription. Otherwise, the generic will be provided.
- If the prescription does not include "Dispense as Written" but the you request the brand name prescription, you will pay the applicable brand copay plus the cost difference between the generic and brand name prescription.
- If there is no generic alternative, the brand name prescription will be filled at the applicable copay.
- Be sure to work with your doctor if you must take a brand name prescription.

Formulary and Formulary Exclusions

- National Preferred Formulary and exclusions are subject to change. Call Express Scripts or visit your Express Scripts member account for the latest information.

Click here to return to Table of Contents

DELTA DENTAL OF ILLINOIS | CONTACT INFO AND USEFUL LINKS

800.323.1743 Delta Dental Website Member Connection Mobile App Provider Finder Plan Overview

DELTA DENTAL®

2023 Dental Plan Summary and Employee Contributions

Benefits	Delta Dental of Illinois		
	PPO Network	Premier Network	Out-of-Network
Annual Deductible			
Individual	$0	$0	$0
Family	$0	$0	$0
Annual Benefit Maximum	$1,500	$1,500	$1,500
Type A - Preventive Services Cleanings, fluoride treatment, exams, x-rays, sealants	Reimbursed at 100%*	Reimbursed at 100%**	Reimbursed at 100% of MPAs***
Type B - Diagnostic/Basic Services Amalgam fillings, oral surgery, non-surgical periodontics, endodontics	Reimbursed at 100%*	Reimbursed at 100%**	Reimbursed at 80% of MPAs***
Type C - Major Services Ceramic restorations (repairs of inlays, onlays, crowns) partial/full dentures, repair of fixed partial dentures, fixed/removable bridges, denture reline/ repair	Reimbursed at 50%*	Reimbursed at 50%**	Reimbursed at 50% of MPAs***
Type D Orthodontia (to age 19)	Reimbursed at 75%*	Reimbursed at 75%**	Reimbursed at 75%*** of MPAs
Orthodontia Lifetime Maximum	$4,800	$4,800	$1,000

**You will not be balance billed for charges exceeding Delta Dental's allowed PPO fees.*

***You will not be balanced billed for charges exceeding Delta Dental's maximum plan allowances (MPAs).*

****You are responsible for charges exceeding Delta Dental's MPAs.*

Employee Contributions (Semi-Monthly)	
Single	$2.25
Single + 1	$4.53
Family	$8.79

Maximum Plan Allowances or MPAs:
The highest dollar amount Delta Dental pays for a covered service. Participating dentists agree not to charge enrollees the difference (if any) between the MPA and the dentist's fee for covered services.

MEMBER CONNECTION

Get real-time benefit and claim information 24 hours a day, seven days a week through the Member Connection at deltadentalil.com or through their automated phone system at 800.323.1743. With Member Connection, you can find everything you need to know about you and your covered dependents' benefits, including:

- Claim Status
- Eligibility information
- Benefit levels
- Frequency and age limits
- Waiting periods
- Preventative history
- Explanation of benefits (EOBs)
- Maximum and deductibles used to date

Click here to return to Table of Contents

Dental Insurance

CHOOSE YOUR DENTIST | PPO NETWORK, PREMIER NETWORK AND NON-NETWORK OPTIONS

You have the flexibility to choose any dentist with your Delta Dental Plan, but your out-of-pocket costs will vary based on your dentist's network.

PPO Network | Lowest out-of-pocket expenses

- PPO network dentists have agreed to accept Delta's established PPO fees as payment in full for services.
- On average, these **fees are 30 percent less** than what the dentist would typically submit for a claim.
- PPO dentists have also agreed not to "balance bill" patients which means they can't bill you for the difference between what they usually charge and Delta's established PPO fee.

Premier Network | Higher out-of-pocket costs than PPO, but may be lower than Non-Network

- Premier is a safety net for Delta's PPO network.
- You will pay more out-of-pocket with a Premier dentist compared to a PPO dentist. However, you may save more money with a Premier dentist compared to a Non-Network dentist.
- Premier dentists agree to Delta's maximum plan allowances as payment in full, which may be lower than what a dentist would typically charge.

Non-Network | Highest out-of-pocket costs

- Non-Network dentists have not agreed to not balance bill or to accept Delta's PPO reduced fees or Premier maximum plan allowance as payment in full.

Example Savings for a Common Procedure*

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
Delta Dental PPO Network	$1,200	$750	50%	$375	$0	$375	$450
Delta Dental Premier Network	$1,200	$975	50%	$487.50	$0	$487.50	$225
Non-Network	$1,200	$975*	50%	$487.50	$225	$712.50**	$0

Delta Dental PPO network

Delta Dental PPO network **dentists have agreed to accept $750 as payment in full for the $1,200 service, a savings of $450** compared to using a non-network dentist. In this example, the **Delta Dental plan covers 50 percent** of the cost. Assuming you've already met your deductible for the year, **Delta Dental will pay $375** and **you'll pay $375.**

Delta Dental Premier® network

Delta Dental Premier network **dentists have agreed to accept $975 as payment in full – a savings of $225** compared to using a non-network dentist. In this example, your **Delta Dental plan covers 50 percent** of the cost. Assuming you've already met your deductible for the year, **Delta Dental will pay $487.50** and **you'll pay $487.50.** That's an extra **$112.50 tacked on to your share of the bill** when compared to what you would have paid with a PPO dentist.

Out-of-network

Out-of-network dentists **have not agreed to accept a lower fee as payment in full and can bill the full $1,200.** In this example, non-network dentists are paid off the Delta Dental Premier maximum plan allowance, so the **maximum allowed fee is limited to $975*.** The dentist can bill you the difference between the maximum allowed fee and what they typically charge.** The **Delta Dental plan would cover 50 percent of the $975, paying $487.50. You would be left with the other half of $487.50 plus the $225 difference** between the dentist's usual fee and Delta Dental's maximum allowed fees. **You would pay a total of $712.50.**

Click here to return to Table of Contents

Enhanced Benefit Program | Oral Health Meets Overall Health

Delta Dental's Enhanced Benefit Program enhances coverage for individuals who have specific health conditions that can be positively affected by additional oral health care. These enhancements are based on scientific evidence that shows treating and preventing oral disease in these situations can improve overall health. If you are eligible, you can sign up through the Delta's Member Connection.

- Delta's Enhanced Benefits Program includes additional cleanings and/or applications of topical fluoride.
- The program addresses the unique health challenges faced by people with conditions that put them at risk for oral health disease, and can also play an important role in the management of an individual's medical condition.
- The costs of the additional cleanings and fluoride treatments, if applicable, will be applied to your annual maximum.
- You must complete a brief health-history statement to be eligible for these important benefits.

Once you are enrolled, you are immediately eligible for the enhanced benefits.

Those eligible for Delta's Enhanced Benefits Program include:

- People with periodontal (gum) disease
- People with diabetes
- Pregnant women
- People with high-risk cardiac conditions
- People with kidney failure or who are undergoing dialysis
- People undergoing cancer-related chemotherapy and/or radiation
- People with suppressed immune systems due to HIV positive status, organ transplant, and/or stem cell (bone marrow) transplant
- People with special needs (physical, medical, developmental and/or cognitive needs)

Individuals with specific health conditions can sign-up for additional annual cleanings and/or fluoride treatments through the Enhanced Benefit Program.

Predetermination for Your Dental Care

It is not required, but Delta Dental recommends that you ask your dentist to predetermine services over $200.

- If your dentist recommends a certain procedure that will cost over $200, ask them to send a predetermination to Delta Dental of Illinois.
- Delta will issue a predetermination that indicates the amount covered for the procedure in advance.
- Assuming no changes are made to eligibility or additional benefits for other claims are paid prior to receiving treatment, you and your dentist will have a better idea how much will be covered under the benefit program and how much you will be required to pay for the service.

Click here to return to Table of Contents

Vision Insurance

VSP VISION I CONTACT INFO AND KEY LINKS

800.877.7195 VSP Website Provider Finder Plan Overview VSP ID Card

vsp® Vision care for life

2023 Vision Plan Summary and Employee Contributions

VSP – Choice Network	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 copay	Up to $45
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)	Up to $60 copay	$0
Standard Contact Lens Fit and Follow-Up	Up to $40	$0
Premium Contact Lens Fit and Follow-Up	10% off retail	N/A
Retinal Imaging	Up to $39	N/A
Frames	$0 copay; $130 allowance; 80% of charge over $130	Up to $70
Standard Plastic Lenses		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $65
Lenticular	$25 copay	Up to $100
Contact Lenses		
Conventional	$0 copay; $130 allowance (in lieu of lenses and frame)	Up to $105
Medical Necessary	$25 copay; Paid in full	Up to $210
Laser Vision Correction		
Lasik or PRK from US Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Please refer to VSP highlight sheet for further information.

Employee Contributions (Semi-Monthly)	
Single	$0.43
Single + 1	$0.80
Family	$1.29

Click here to return to Table of Contents

Member Account

Create an account on vsp.com to view your in-network coverage, find network doctors and discover savings with exclusive member extras. Download the VSP Vison Care App from your app store to manage your eye care needs at anytime, from anywhere.

Premier Program

Maximize your coverage with bonus offers and savings that are exclusive to VSP's Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

VSP Network Coverage

When it comes to choices, VSP® has your employees and their eyes covered with a huge network of independent doctors, popular retailers, and an online option.

Independent Doctors

- Largest network of independent doctors
- 24-hour access to emergency care
- Integrated medical management with VSP Healthy Innovations

Premier Providers

- VSP Premier program locations, where employees can maximize their benefits, include both private practice doctors and more than 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM | Visionworks

*Log in to confirm in-network locations based on plan type.

Retail Options

VSP provides a truly personalized network for your employees. In addition to Visionworks, your employees have access to retail chains including:

COSTCO OPTICAL | PEARLE VISION | Sam's Club Optical | Walmart | Visionworks | ROSIN EYECARE Chicago's First Choice in Vision Care.

Buy Online, Anytime!

VSP members can shop the latest designer glasses and name brand contacts online at **eyeconic.com**® with their VSP benefits.

eyeconic

Click here to return to Table of Contents

Health Insurance Opt-Out Incentive

Program Details

If you have health insurance from somewhere else, you may be eligible to receive a cash incentive from the City!

To participate in the opt-out incentive program, you must waive medical, dental and vision insurance coverage (as described below) from the City, complete the Health Insurance Opt-Out Form and provide supporting documentation showing proof of medical insurance coverage elsewhere as well as proof of dependency for your dependents if electing the Plus One or Family tier incentive.

Annualized Incentive Value by Waived Coverage Tier

Single	Plus One	Family
$2,000	$3,000	$4,000

Please keep in mind the following information regarding the City's health insurance opt-out program:

- All payments are subject to taxes and withholdings, and shall be issued to the employee via payroll on a semi-monthly basis through your payroll check.
- The duration of the health insurance opt-out qualifies for one plan year (January 1–December 31).
- Employees who opt-out of the insurance program mid-year due to a qualifying life event, shall receive the incentive payment on a pro-rated basis.

To participate in the Health Insurance Opt-Out Program During the Benefit Enrollment Period:

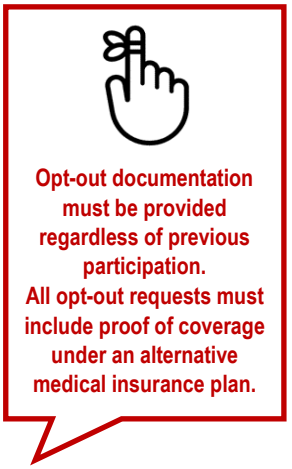
- Waive medical, dental and vision coverage via eSuite by the open enrollment deadline.
- Complete the Health Insurance Opt-Out Form and attach a copy of the your proof of medical coverage elsewhere (applicable medical insurance card or letter verifying coverage in another medical insurance plan) and return the form and supporting documentation to hr@desplaines.org by open enrollment deadline.

Health Insurance Opt-Out Incentive

Health Insurance Opt-Out Form Details

The health insurance opt-out form requires the following information regarding your medical insurance coverage elsewhere.

- Insurance carrier name
- Employer name
- Policy/Group number
- Effective date of coverage
- Subscriber/Member
- Member ID
- Employer/Group
- Member Services phone number
- Person who can verify coverage
- Phone number of verifying person
- Type of coverage (Single, Single +1, Family)
- Copy of medical insurance card or letter verifying coverage in another medical insurance plan
- Proof of dependency documentation for your eligible dependents if electing Plus One or Family tier level opt-out



Click here to return to Table of Contents

Life Insurance | City-Paid and Supplemental

SECURIAN FINANCIAL LIFE INSURANCE | CONTACT INFO AND USEFUL LINKS

800.392.7295 Securian Website COMING SOON! Plan Overview Beneficiary Designation Form

Life insurance coverage can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your or your family member's passing.

To make a life insurance claim, please contact the Human Resources Department.

CITY-PAID LIFE INSURANCE

All full-time employees are provided with a group life insurance including accidental death and dismemberment (AD&D) while employed by the City. The City pays the full-cost of this coverage. Employees are responsible for designating beneficiaries and for keeping such designations current. Coverage ceases on the last day of employment.

Classes	Life Benefit Amount
Non-Union Management, IAFF Officers and MAP #241 Employees	$100,000
MAP #240, IAFF, AFSCME, MECCA (PW) and Non-Union Non-Management Employees	$70,000

AD&D Insurance	For a covered accidental loss of life, your basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.

SUPPLEMENTAL LIFE INSURANCE

The City also offers supplemental life insurance programs that you may elect for yourself and dependents. You pay the full premium costs for supplemental life insurance through payroll deductions. Coverage ceases on your the last day of employment.

Eligible employees can sign-up for or increase supplemental life insurance coverage:

- Upon Hire within 30 days (coverage amounts exceeding the guarantee issue amounts, $300k employee / $50k spouse, require medical underwriting approval)
- During Annual Open Enrollment (medical underwriting approval is required)
- For a Qualified Life Event (medical underwriting approval is required for coverage exceeding guaranteed issue amounts or where underwriting approval was previously declined)

If you are enrolling for the first time outside of your new hire enrollment, you must submit an Evidence of Insurability Questionnaire for medical underwriting review.

If you are recently a new parent, married or divorced, please remember that you can update beneficiary information on your life insurance, retirement plans and pension at any time.

Click here to return to Table of Contents

Supplemental Life Insurance

SUPPLMENTAL EMPLOYEE AND SPOUSE LIFE INSURANCE

You may select the amount of supplemental life insurance for which you are interested in applying within the coverage amount guidelines shown below. You select the amount of employee supplemental life and dependent life insurance for which you are interested in applying.

	Minimum	Benefit Amount	Guarantee Issue Amount	Maximum
Employee	$10,000	Increments of $10,000	$300,000	$750,000
Spouse	$10,000	Increments of $10,000	$50,000	$500,000

You must enroll in supplemental employee life insurance in order to enroll in supplemental dependent life insurance.

NOTE:

- Employee supplement coverage is based on your age as of the first of the year.
- Employees must be insured under employee supplemental life coverage in order to elect spouse life coverage for the first time.
- The coverage amount for your spouse cannot exceed 100% of your combined basic and supplemental life coverage.
- Amounts of coverage elected above the guarantee issue amount are subject to medical underwriting approval.
- All late application (applying more than 30 days after full-time hire) requests for coverage increases and reinstatements are subject to medical underwriting approval with the exception of new or increased coverage elections made during a qualifying event for coverage amounts at or below the guarantee issue amount.
- Employees and spouses eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- Under this plan, your coverage amount reduces by your age as follows: by 35% at age 65, by 50% at age 70, and by 70% at age 75.
- Employees pay 100% of the premium for this coverage through payroll deduction.
- Applicable premiums will be deducted from employees' payroll checks on a semi-monthly basis (1st two pay periods of each month). Half the monthly premium will be deducted on the 1st payroll of the month and half on the 2nd payroll of the month.

EMPLOYEE AND SPOUSE MONTHLY RATES	
Employee's Age As of January 1	Rate (Per $1,000 of Total Coverage)
<25	$0.055
25-29	$0.065
30-34	$0.080
35-39	$0.095
40-44	$0.120
45-49	$0.180
50-54	$0.275
55-59	$0.455
60-64	$0.780
65-69	$1.270
70-74	$2.300
75+	$3.720

FAMILY PLAN COVERAGE

The Family Plan provides coverage in the amount of $10,000 for your spouse and $5,000 for your eligible child(ren). Dependent life insurance pays a benefit in the event of insured dependent's death. The employee pays the full cost of this coverage.

The cost is $0.26 monthly regardless of the number of dependents. Premiums for this coverage will be deducted directly from employees' paycheck on a semi-monthly basis. $0.13 will be deducted on the 1st payroll of the month and $0.13 on the 2nd payroll of the month.

Click here to return to Table of Contents

Flexible Spending Accounts (FSA)

WEX / DISCOVERY BENEFITS | CONTACT INFO AND USEFUL LINKS

866.451.3399 WEX Website Member Login Medical FSA Flyer Dependent FSA Flyer

Flexible Spending Accounts (FSA)

Flexible spending accounts allow you to set aside pre-tax dollars to reimburse yourself for eligible out-of-pocket expenses.

- FSAs elections are good for the calendar year only. You must re-enroll if you want to participate in 2023. If you do not enroll by the open enrollment deadline, you will not be able to participate in the FSA program in 2023.

Medical FSA

A medical FSA allows you to save money by setting aside dollars from your paycheck on a pre-tax basis for eligible out-of-pocket medical, prescription, dental and vision expenses. Please visit see WEX's Eligible Expense List for more details.

- Your full annual contribution amount is available for your use as of the first of day of the plan year.
- Your contributions are deducted from your payroll check on a semi-monthly basis (1st two pay periods of each month).
- Program participants receive a debit card that can use to pay for eligible expenses.
- To be eligible, you or your spouse cannot be actively enrolled and contributing to a health savings plan (HSA).
- NOTE: The IRS has not announced the maximum annual contribution amount for 2023 to date. For planning purposes, please assume a $2,850 limit.

FSAs are "Use It or Lose It" Any money left in your accounts after the plan year Grace Period is forfeited!

You have until 3/15/2024 to incur expenses against your 2023 FSA contributions and until 3/31/2024 to substantiate your claims.

Unsubstantiated claims are subject to tax.

Dependent Care FSA

A dependent care FSA allows you save money by setting aside dollars from your paycheck on a pre-tax basis for eligible dependent care expenses, such as child care for dependents under the age of 13, elder/adult daycare or disabled dependent care.

- Unlike medical FSAs, dependent FSAs are not pre-funded. You can only be reimbursed up to the amount you have had deducted from your payroll checks.
- To be eligible for the dependent care FSA, you and your spouse (if applicable) must be employed full time or your spouse (if applicable) must be a full-time student or looking for work.
- The IRS has not announced the maximum annual contribution amount for 2023 to date. For planning purposes, please assume a $5,000 limit for single and married couples filing taxes jointly and a $2,500 limit for married couples filing taxes separately.

Download the Discovery Benefits mobile app to manage your benefits on the go.
From the app, you can check your account balances, upload photos of your receipts, file claims and view claim activity.

Click here to return to Table of Contents

WEX / DISCOVERY BENEFITS | CONTACT INFO AND USEFUL LINKS

866.451.3399 WEX Website Member Login Commuter Benefit Flyer

Transit Benefits | Mass Transit and Parking

Transit benefits allow you to save money by setting aside dollars from your paycheck on a pre-tax basis for eligible mass transit and parking expenses for your commute to and from work.

- Transit benefit elections are only good for the calendar year. You must re-enroll if you want to participate in 2023. If you do not enroll by the open enrollment deadline, you will not be able to participate in 2023.
- Your funds become available as you contribute to the plan, generally within 2-3 days after your payroll contribution.
- You can adjust the amount you contribute to the plan each month. No qualifying event is needed. Simply, contact the HR at hr@desplaines.org to update your contributions.
- The transit plan is flexible and your funds will continue to roll-over month to month until the funds are used. However, your funds will no longer be available if you terminate employment.
- Participants can either submit eligible expenses for reimbursement or use their WEX/Discovery Benefits debit card to pay for eligible expenses.
- Only an employee's commuting expenses are eligible for this program. Commuting expenses incurred by an employee's dependents are not eligible.
- NOTE: The IRS has not announced the maximum annual contribution amount for 2023 to date. For planning purposes, please assume a $280 monthly limit for both the mass transit and parking commuter benefits.

Click here to return to Table of Contents

Employee Assistance Program (EAP)

LIFEWORKS EMPLOYEE ASSISTANCE PROGRAM | CONTACT INFO AND USEFUL LINKS

855.773.0207 LifeWorks Website (User ID: CityofDesPlaines Password: 60016) EAP Flyer Mobile App

LifeWorks by Morneau Shepell

THE EMPLOYEE ASSISTANCE PROGRAM is a free and confidential program that offers resources to support employees' and their household members' mental, physical, social and financial well-being.

Resources range from personalized counseling sessions, self-guided assessments and resource libraries, financial and legal consultations, online fitness programs and coaching to vacation planning and discount movie tickets.

- Resources are available 24/7!

CUSTOM COUNSELING PLANS

- Employees or their household members work together with a clinician to determine the appropriate number of sessions required to meet the unique needs of the individual and situation.
- Professionally trained advisors are available 24/7 to help with family problems, marital concerns, financial and legal matters, stress, depression and other issues affecting employees' and their family members' personal or work life.

PERSONALIZED ACCOUNTS

Create your own custom experience by choosing topics of interest delivered in your own well-being feed. Plus take advantage of well-being assessments and self-guided, care solutions.

SERVICES INCLUDE

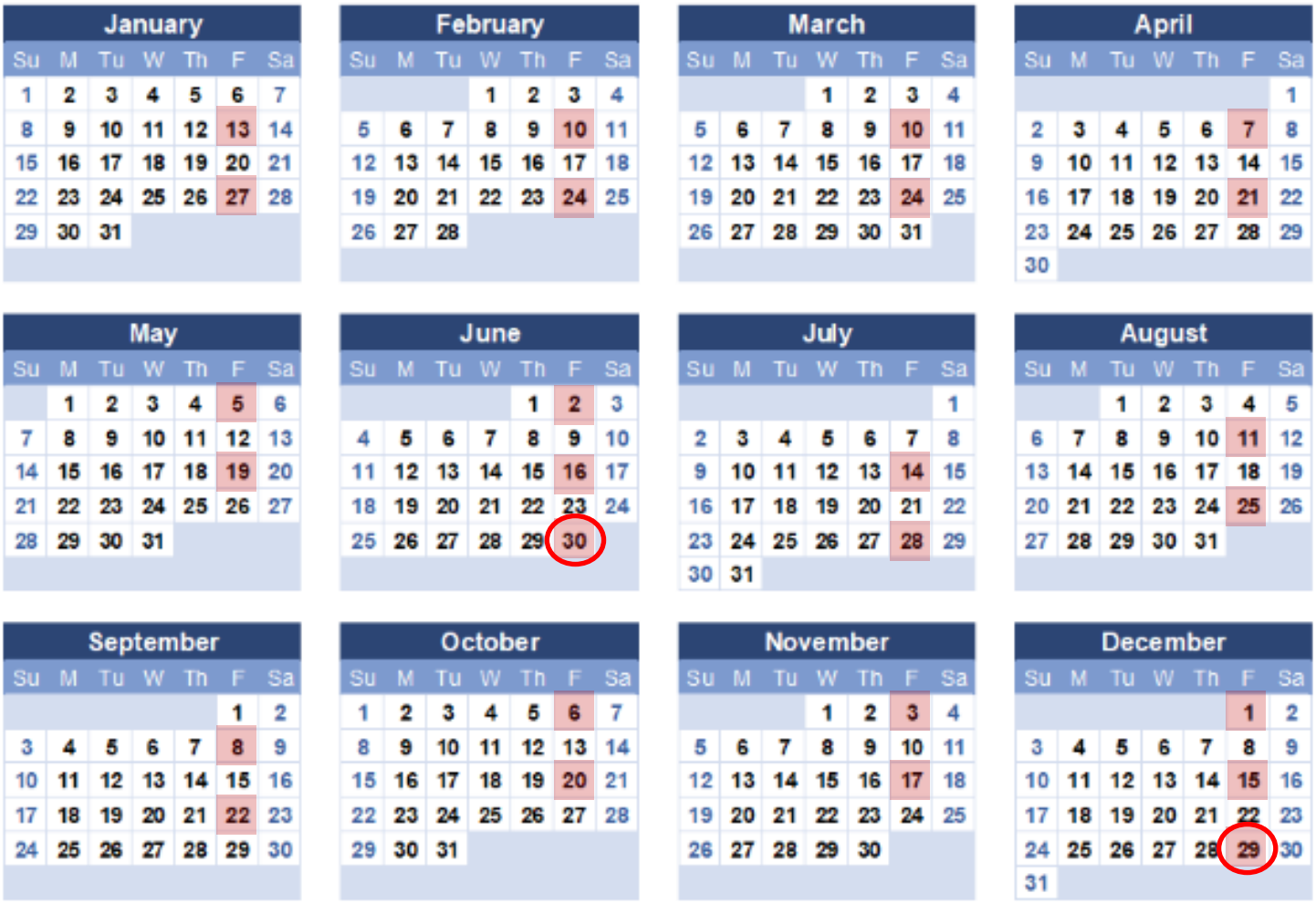
- Immediate Access to Trained Professional Advisors
- Custom Counseling Plans
- Personalized Well-Being Content, Tools and Resources
- Financial and Legal Assistance
- Child, Elder and Pet Care Resources
- Online Fitness and Coaching
- Vacation Planning
- Assistance with Big Purchases
- Bi-Weekly On-Demand Webinars
- Thousands of Perks and Savings Opportunities And More!

CONFIDENTIALLY IS KEY

Calls to the EAP are confidential. All information that you share with counselors is also confidential and cannot be shared with employers or other parties without your consent. Employers receive only summary information about the number of calls and visits to the program that took place.

Click here to return to Table of Contents

2023 Payroll Calendar



= Pay Day = Third Pay Day of the Month

Deducted 24 Times Per Year 1st Two Pay Days of Each Month	Deducted 26 Times Per Year Every Pay Day
• Medical Insurance • Dental Insurance • Vision Insurance • Supplemental Life Insurance • Accident Plan Insurance • Flexible Spending Accounts • Transit Benefit Accounts	• Pension Contributions • 457/401a Plan Contributions • Roth IRA Contributions • IMRF Additional Voluntary Contributions • Applicable Federal, State, Social Security and Medicare Taxes

**Union Dues deductions will continue per current deduction schedule*

***Wage garnishments will be deducted according to the terms of the garnishment order*

Click here to return to Table of Contents

Qualifying Life Events

Qualifying Life Events for Mid-Year Medical, Dental, Vision, Life Insurance and Flexible Spending Account Changes

Changes to your benefits can be made outside of open enrollment only if preceded by a documented qualified life event and made within 30 days of the event. Your change must be consistent with your life event/status change.

Listed below are some events that qualify for a change in coverage.

- Marriage
- Civil union
- Divorce or legal separation
- Birth or placement for adoption of a child
- Ineligibility of a dependent
- Loss of other coverage
- Change in your employment status or that of your spouse/dependent
- Court order
- Entitlement to Medicare or Medicaid

If you experience one of these events and want to change your benefits, you must make the change within 30 days after the event occurs. If you miss the window for making a change, you will need to wait until the next open enrollment period to make a change.

Acceptable Proof of Dependency Supporting Documentation

Legally Married	Copy of official state marriage certificate or civil union certificate
Biological Child	Copy of child's official state birth certificate Newborns Only: Copy of the crib card or hospital discharge papers if birth certificate is not yet available. Employee must follow-up with the birth certificate
Adopted Child	Copy of adoption papers signed by a judge and copy of child's official state birth certificate
Step Child	Copy of child's official state birth certificate and copy of official state marriage certificate
Legal Ward	Copy of court documents signed by a judge, copy of child's official state birth certificate and proof of permanent residency
Child with Physical or Mental Incapacity that Occurred Before the Age of 26	Disability certification form in addition to documentation listed above depending on the relationship

Benefit Election Planning for Open Enrollment

The pension code for the Police Pension, Fire Pension and IMRF (215 ILCS 5/367) states that only retirees and dependents on the health plans the day before retirement have the right to maintain coverage. If you are planning on continuing City coverage in retirement please consider the following.

- You cannot add dependents to your City coverage after your retire. Also, once you drop a dependent from your retiree coverage you cannot re-enroll them.
- You can only continue coverage in plans for which you were enrolled in the day before your retirement. For example, you cannot enroll in retiree vision coverage if you were not enrolled in vision coverage the day before retirement.
- Once your drop City coverage in retirement you cannot re-enroll.
- In retirement, you can switch between HMO, PPO2 and PPO3 plans during annual open enrollment.
- If you are planning on retiring in 2023, ensure your elections are appropriate with this Open Enrollment Period!

Pensions

For employees enrolled in the Fire and Police pensions, please contact your pension representative regarding your upcoming retirement plans and your pension schedule.

For employees enrolled in IMRF, please visit your IMRF member account or contact member services at 800.275.4673.

- IMRF Tier 1 Retirement Benefits
- IMRF Tier 2 Retirement Benefits
- **Be sure to check out IMRF's Retirement Checklist located on the above linked pages.*

Retirement Savings Plans

If you contribute to the Mission Square (formerly ICMA-RC) 457 Plan or Roth IRA or participated in the City's Retirement Health Savings Plan, please contact the City's representative for information regarding accessing your funds in retirement.

Danka Durkiewicz
Mission Square, Retirement Plan Specialist
202.759.7159 | ddurkiewicz@missionsq.org

If you contribute to the Nationwide 457 Plan, please contact the City's representative for information regarding accessing your funds in retirement.

Brian W Miller, CFP, CRC
Nationwide Financial, Sr. Retirement Specialist
847.573.0156 | milleb24@nationwide.com

If you contribute to IMRF's Voluntary Additional Contributions, please contact IMRF for your fund distribution options.

Click here to return to Table of Contents

Retirement Savings

457 Deferred Compensation Plans

A 457 deferred compensation plan allows you to save and invest money for retirement with tax benefits.

- Contributions are made to an account in your name, through payroll deductions, for the exclusive benefit of you and your beneficiaries.
- The value of the account is based on the contributions made and the investment performance over time.
- A 457 plan is designed to supplement your retirement income. While a pension and/or Social Security may go a long way, they may no to be enough.

Contributions

- Pre-tax contributions you make reduce your taxable income for the year.
- These contributions and all associated earnings are then not subject to tax until you withdraw them.

Investments

- You control how your account is invested, choosing from options available through the City's vendors.
- A typical plan includes a wide range of options, from more conservative stable value funds to more aggressive bond and stock funds.

Withdrawals

- You can make withdrawals from your account when you leave employment. You have the ability to take payments as needed or request scheduled automatic payments. You maintain control over your investments and continue to benefit from tax deferral even after you leave your employer.
- Withdrawals are generally taxable but, unlike other retirement accounts, the 10% penalty tax does not apply to distributions prior to age 59½.

Survivor Benefits

- You designate a beneficiary or beneficiaries to receive any remaining assets upon your death.
- Designating beneficiaries can help ensure your assets are paid per your wishes, avoid the potential costs and delays of probate and allow non-spouse beneficiaries to receive additional tax benefits.

457 Plans are offered through Mission Square (formerly ICMA-RC) and Nationwide

- Sign-up at the below links or contact the City's retirement plan representatives for more information.

icmarc.org/enroll
Danka Durkiewicz
Mission Square, Retirement Plan Specialist
202.759.7159 | ddurkiewicz@missionsq.org

MissionSquare RETIREMENT

NRSFORU.com
Brian W Miller, CFP, CRC
Nationwide Financial, Sr. Retirement Specialist
847.573.0156 | milleb24@nationwide.com

Nationwide

Click here to return to Table of Contents

Roth IRA

A Roth IRA is a tax-advantaged account that holds investments to provide you with income in retirement.

- You contribute to a Roth IRA from your earned income after you pay regular income taxes—unlike a traditional IRA, there is no upfront tax break with a Roth IRA.
- The tax benefits come later, as you pay no income tax on qualified withdrawals of contributions and earnings.
- You can withdraw contributions you've made to your Roth IRA penalty-free, for any reason, at anytime.
- Roth IRAs are subject to specific income limits.

Roth IRA's, with the convenience of payroll deductions, are offered through Mission Square (formerly ICMA-RC)

- Sign-up at the below link or contact the City's retirement plan representative for more information.

icmarc.org/enroll
Danka Durkiewicz
Mission Square, Retirement Plan Specialist
202.759.7159 | ddurkiewicz@missionsq.org

MissionSquare RETIREMENT

457 Plan and Roth IRA Contribution Limits

- The 2022 contribution limits are listed below. The 2023 limits have not been announced to date.

Plan	Normal Limit	Age 50 Catch-Up Additional Contribution Limit	Pre-Retirement Catch-Up Additional Contribution Limit
457 Plan	$20,500	$6,500	$20,500
Roth IRA	$6,000	$1,000	N/A

Click here to return to Table of Contents

IMRF Voluntary Additional Contributions (VAC)

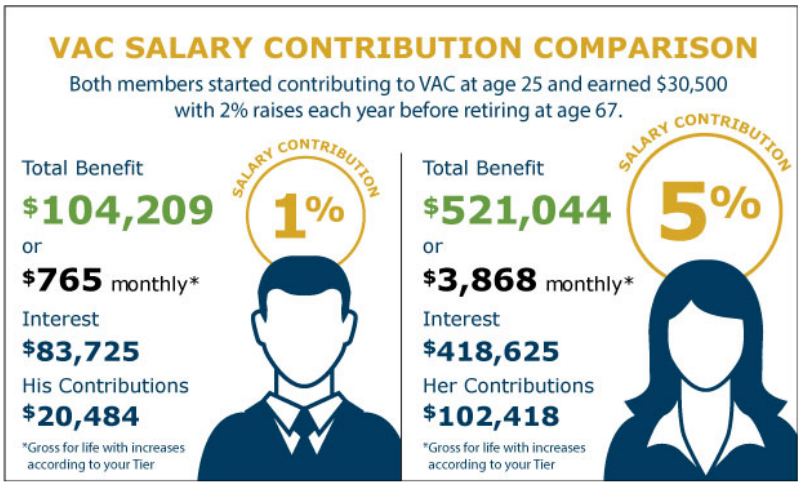
ILLINOIS MUNCIPAL RETIREMENT FUND VAC I CONTACT INFO AND USEFUL LINKS

800.275.4673 IMRF Website Tier 1 VAC Plan Overview Tier 2 VAC Plan Overview VAC Form

IMRF's VAC Program is an Easy Way to Help You Save Additional Retirement Income

- Tier 1 members may contribute up to a maximum of 10% of your IMRF reportable earnings through payroll deductions.
- Tier 2 members may contribute up to a maximum of 10% of your IMRF reportable earnings, up to the Tier 2 wage cap, through payroll deductions.
- Contributions are made after-tax through payroll deductions. They are not tax-deferred like usual IMRF member contributions.
- Unlike the Voluntary Additional Contributions themselves, the interest credited is tax-deferred.
- You can start, stop, increase or decrease your VAC contributions at any time.
- Although you can apply for a refund of your contributions at anytime, IMRF discourages refunds.
- The VAC program is intended to supplement to retirement income. If you want a short-term savings option, VAC may not be the right choice.

The VAC program is only available to employees enrolled in IMRF.



Retiring with Voluntary Additional Contributions

If you leave your VAC on deposit until you retire from IMRF, at retirement, you may choose to receive your Voluntary Additional Contributions as either:

- A monthly annuity if your VAC balance is $4,500 or more
- A lump sum

Click here to return to Table of Contents

IMRF Voluntary Additional Contributions (VAC)

Interest is Credited Differently from a Traditional Savings Account

- A traditional savings account credits interest on the current amount in the account. IMRF credits interest annually, at the end of the year based on the previous January 1 balance.
- You will not earn any interest the first year you begin making Voluntary Additional Contributions.
- If you withdraw your contributions at any time during a year, you will not receive any interest on the contributions you withdraw. Contributions must stay in your account for you to receive interest on them. However, you would receive interest on any previously earned interest that remains in your account.
- The current rate of interest is 7.25%. This rate may change in the future. If it does, IMRF may not directly notify you.

7.25%

Current Interest Rate

How VAC interest is credited (example assumes 7.25% interest rate)

1ST YEAR

January 1, 2019 opening balance	$0.00
VAC contributions made during 2019	$400.00
Interest credited on December 31, 2019 based upon January 1, 2019 balance of $0 x 7.25%	$0.00

2ND YEAR

January 1, 2020 opening balance	$400.00
VAC contributions made during 2020	$500.00
Interest credited on December 31, 2020 based upon January 1, 2020 balance of $400 x 7.25%	$29.00

3RD YEAR

January 1, 2021 opening balance:	
2019 VAC contributions	$400.00
2019 interest	$0.00
2020 VAC contributions	$500.00
2020 interest	$29.00
Total January 1, 2021 opening balance	$929.00
Interest credited on December 31, 2021 based upon January 1, 2021 balance of $929 x 7.25%	$67.35

Although the Voluntary Additional Contributions program offers you an easy way to save for retirement, only you know if it is right for you. If you are uncertain about making Voluntary Additional Contributions or the tax consequences of Voluntary Additional Contributions refunds, you should contact your financial advisor.

Enrolling in IMRF's VAC Program

- Simply complete the VAC Form and return your completed form to the HR for processing.

Click here to return to Table of Contents

Glossary of Employee Benefit Terms

- **ALLOWED AMOUNT:** Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)
- **BALANCE BILLING:** When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider should not balance bill you.
- **BENEFICIARY:** The person(s) you name to receive certain benefits (such as life insurance) upon your death.
- **BRAND NAME DRUG:** Medications are marketed under a trademark-protected name and are often available from only one manufacturer.
- **COINSURANCE:** The percentage of covered medical or dental expenses that you must pay. For example, if your plan pays 80%, you must pay the remaining 20%.
- **COPAYMENT:** A fixed amount you pay for a covered healthcare service, usually at the time of service.
- **DEDUCTIBLE:** The amount of medical or dental expenses you must pay each year before your plan begins paying benefits.
- **DEDUCTIBLE CARRY-OVER:** In some benefit plans, not Health Savings Account Compatible Plans, if you have not met your annual deductible during the last three months of the plan year the claims incurred may apply toward the deductible for the next plan year.
- **EMERGENCY MEDICAL CONDITION:** An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.
- **EVIDENCE OF INSURABILITY (EOI):** An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.
- **EXPLANATION OF BENEFITS (EOB):** The document you receive from the insurance company after your claim is filed and processed. The EOB shows how much of the expense the plan covered and how much you may be
- expected to pay.
- **FORMULARY BRAND NAME DRUG:** A list of prescribed medications that are preferred by your plan because they are deemed to be safe, effective alternatives to other generics or brands that may be more expensive.
- **HIPAA (Health Insurance Portability and Accountability Act of 1996):** A federal law that addresses the privacy of patient health information. The "privacy" regulations give patients greater access to their own medical records and more control over how their personal health information is used. Also, the law defines the obligations of health care providers and health plans to protect patient records.
- **HOSPITALIZATION:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
- **HOSPITAL OUTPATIENT CARE:** Care in a hospital that doesn't require an overnight stay.
- **IN-NETWORK PROVIDER:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Click here to return to Table of Contents

Glossary of Employee Benefit Terms

- **MAXIMUM ANNUAL BENEFIT:** The maximum amount the plan pays for specific services (such as dental or chiropractic) for a covered individual, each plan year.
- **MEDICAL GROUP:** A medical group is a collection of physicians who have come together contractually or in partnership for the purposes of managing a practice and sharing the care of patients.
- **MEDICALLY NECESSARY:** Services and supplies that the insurance company determines to be consistent with generally accepted practices for the diagnosis of an illness or injury, or the medical care of a diagnosed illness or injury. Only medically necessary services and supplies are covered by the plan.
- **OUT-OF-NETWORK PROVIDER:** The facilities, providers and suppliers who don't have a contract with your health insurer or plan to provide services to you. You will generally pay more to see an out-of-network provider.
- **OUT-OF-POCKET LIMIT:** Is the most you have to pay for covered medical expenses in a year. Once you've reached the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. This limit never includes your premium, balance-billed charges or charges the plan doesn't cover.
- **PLAN:** A benefit your employer, or other group sponsor provides to you to pay for your healthcare services.
- **PLAN YEAR:** The period of time in which plan coverage and records are based.
- **PRE-AUTHORIZATION:** A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or pre-certification.
- **PREMIUM:** The amount you pay for your health care coverage and other benefits, through payroll deductions.
- **PRIMARY CARE PHYSICIAN:** A physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. The following types of providers are PCPs: family practitioners, general practitioners, pediatricians, internal medicine, and gynecologists. HMO members must designate a PCP.
- **SPECIALIST:** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions
- **URGENT CARE:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
- **VOLUNTARY BENEFITS:** Optional benefit plans sponsored by the employer, but fully paid for by employees who elect coverage. These benefits are generally available at special group rates or discounts, making them more cost-effective than employees could obtain on their own.
- **WOMEN'S PRINCIPAL HEALTH CARE PROVIDER (WPHCP):** Women who are HMO members have the option to designate a WPHCP, in addition to their primary care provider. The WPHCP must be affiliate with or employed by the member's principal medical group.

This glossary is provided for general information and convenience.
Employees should review their plan documents for definitions of terms.

Click here to return to Table of Contents

Federal and State Notices

COMPLIANCE NOTICES

can be found on the City's Benefits Portal

- 2022 Consumer Coverage Disclosure Act
- CHIPRA State Premium Assistance Notice
- COBRA Continuation of Coverage Initial Notice
- Health Insurance Marketplace Notice Expires 06.30.2023
- HIPAA Notice of Privacy Practices
- NMHPA Notice
- Patient Protections Disclosure
- Women's Health and Cancer Rights Act
- Special Enrollment Notice