City of Des Plaines

2025 Benefits Guide

DES PLAINES
ILLINOIS

FULL-TIME EMPLOYEES

Community & Economic Development

Public Works & Engineering

City Manager's Office

Finance | Fire | Police

What's new?

SUPPLEMENTAL LIFE INSURANCE CHANGES

To confirm your current Life insurance elections, please contact Human Resources.

Supplemental Employee Life $10,000 Increase Opportunity

- During annual open enrollments, employees enrolled in supplemental employee life coverage may elect to increase their coverage by $10,000 without the requirement to complete a health questionnaire and undergo underwriting approval, provided that the resulting amount of total insurance does not exceed the $300,000 guaranteed issue limit.

Dependent Life Package

- Dependent Life Package enrollment is limited to new hires and eligible qualifying life events such as marriage and the birth of a child.
- The Dependent Life Package provides coverage in the amount of $10,000 for a spouse and $5,000 per eligible child for a cost of only $0.26 per month.

Click here to return to Table of Contents

Table of Contents

This document is an outline of benefits and coverage. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request. The intent of this document is to provide you with general information regarding

Click here to return to Table of Contents

2025 Open Enrollment Instructions

2025 BENEFIT OPEN ENROLLMENT VIA ESUITE | INSTRUCTIONS
OPEN ENROLLMENT: MONDAY, OCTOBER 21 - FRIDAY, NOVEMBER 1, 2024

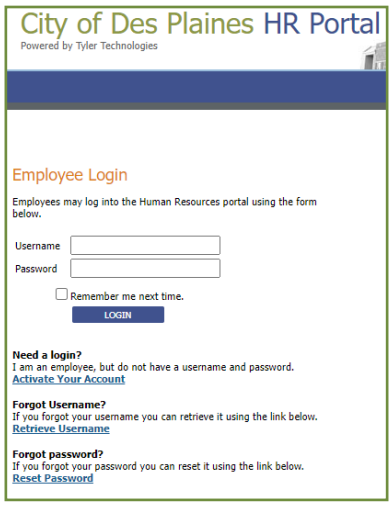
No Paper Enrollment Forms !

Benefits enrollment will be completed online through your Employee Portal.

- Employees making changes to their medical, dental, vision, or supplemental life insurance benefits –OR- enrolling in flexible spending accounts or transit benefits MUST complete their 2025 enrollment online through their Employee Portal.
- If you do not complete enrollment through the portal, your 2024 benefit elections will be carried over into 2025, 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 2025, you MUST complete your 2025 benefit elections through your Employee Portal. (Your 2024 elections will NOT carry over.)
- Even if you are not planning on changing your benefits, you are encouraged to enroll in benefits via your Employee Portal. 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@desplainesil.gov or call 847.391.5486 to schedule an appointment.

STEP 1 | LOG INTO YOUR ESUITE ACCOUNT

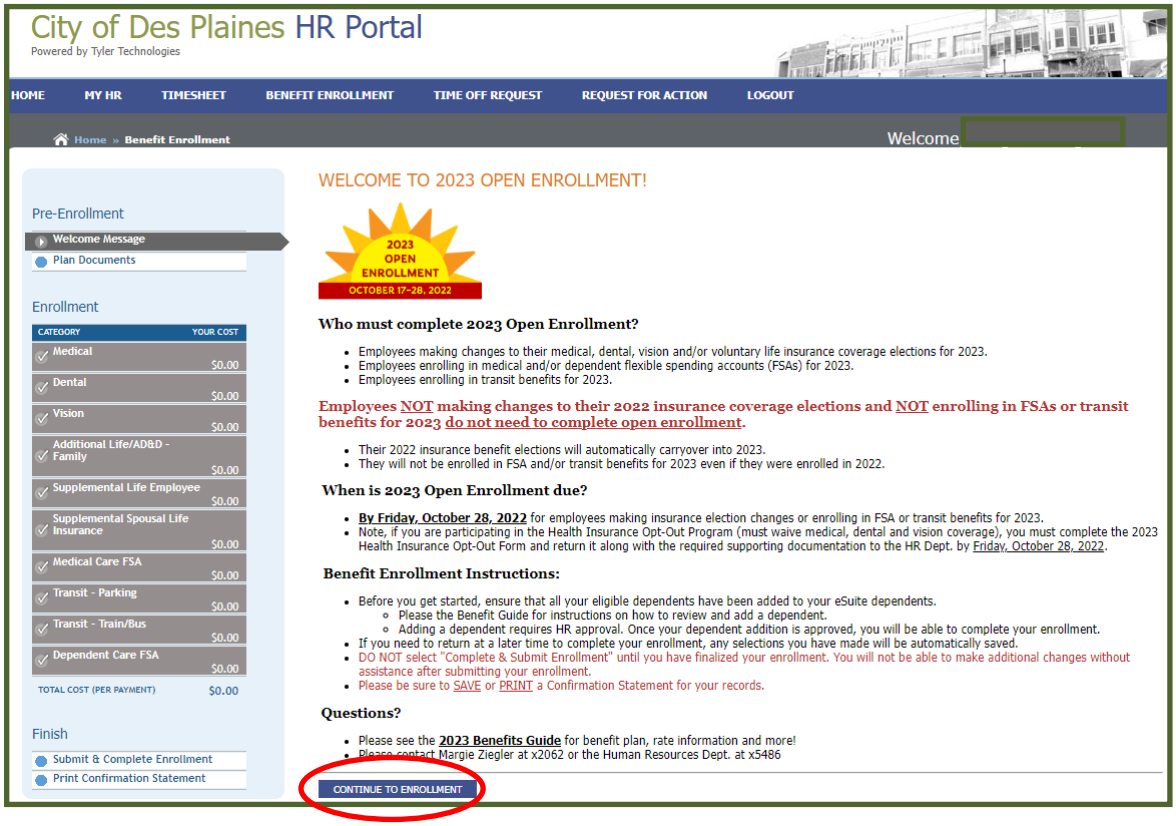
If you've never logged in or forgot your username or password, please use the handy links located at the bottom of your Employee Portal Login page.



STEP 2 | SELECT BENEFIT ENROLLMENT AND THEN OPEN ENROLLMENT

Click here to return to Table of Contents

STEP 3 | BEGIN YOUR BENEFIT ENROLLMENT



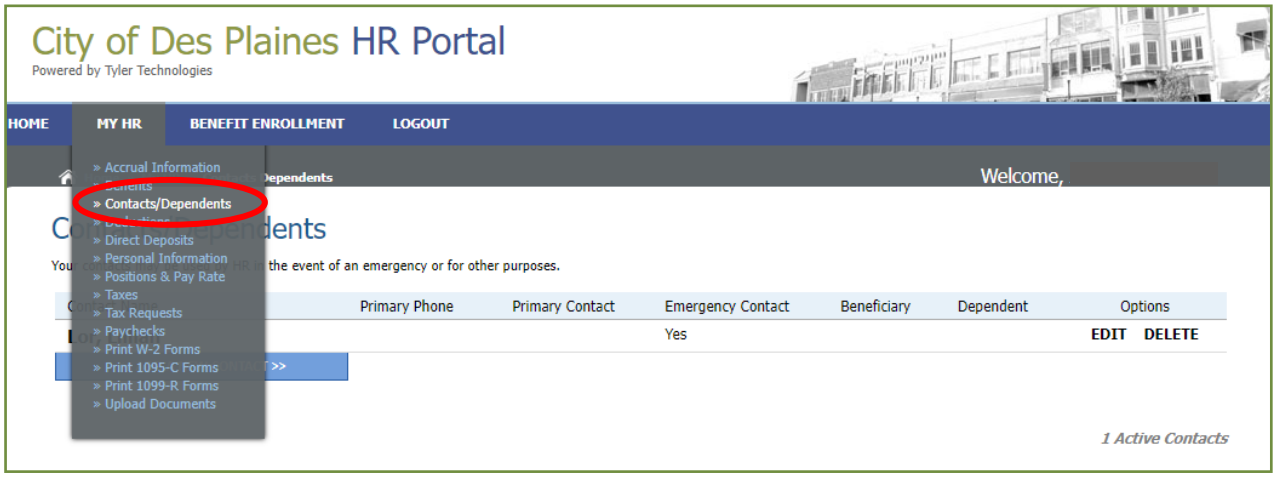
- Please read the Welcome Message and then click the “Continue Enrollment” button to begin your enrollment.
- The system will walk you through each benefit category.
    - Please read the benefit screen instructions and select a benefit option and coverage tier if applicable (Single, Family or Single +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 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 to 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 can no longer 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

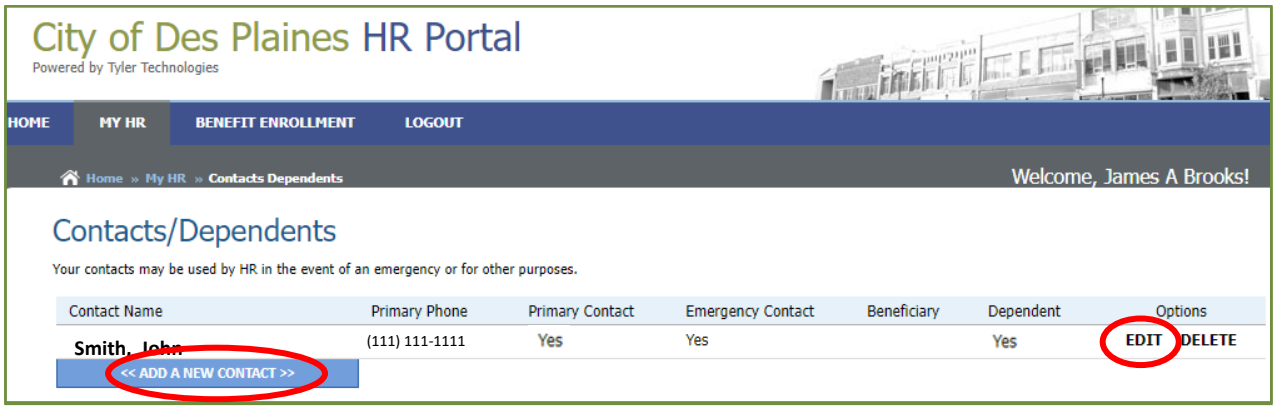
2025 Open Enrollment Instructions

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’s 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 your Employee Portal.
- NOTE: You can also designate the dependent as you Primary Contact or Emergency Contact by selecting the applicable boxes and filling in their 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 28 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 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. (e.g. marriage, date of birth). Contact the HR Dept. learn more about the process.
- Please see page 28 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 Securian Financial Beneficiary Designation Form and return the form to Human Resources for processing.
- 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 your completed 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

2025 Medical Plan Options and Employee Contributions

Major Medical Coverage	Blue Cross Blue Shield of Illinois PPO Option 2 – P14926	Blue Cross Blue Shield of Illinois PPO Option 3 – P14930	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	$43.58	$42.41	$35.13
Single + 1	$84.79	$82.40	$71.63
Family	$122.27	$121.49	$103.68

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

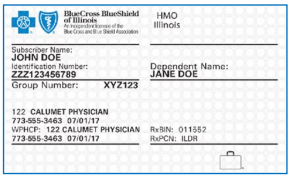
- Typically, HMOs have lower monthly premiums.
- You can also expect to pay less out of pocket.
- HMO care networks are generally smaller.
- Your healthcare services are coordinated by your designated Primary Care Physician (PCP) or Medical Group (MG).
- You must obtain referrals from your PCP/MG to 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.

DECIDING WHERE TO GO FOR CARE | If you aren't experiencing a medical emergency, deciding where to go for medical care may save you time and money. Use the SmartER Care chart to help you figure out where to go.

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. Access claim 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.

Take advantage of resources offered by BCBSIL.

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.
- If you are searching for a PPO provider, please select "Participating Provider Organization [PPO]".

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 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.

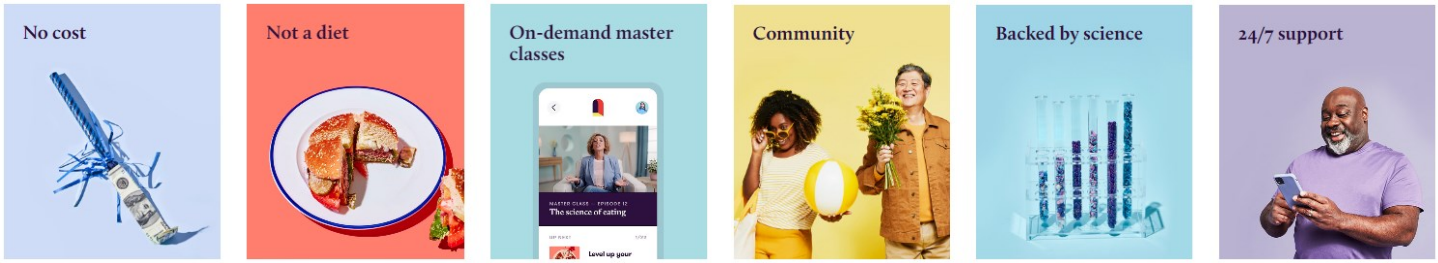
Click here to return to Table of Contents

Medical Insurance

FITNESS PROGRAM | One Membership, Countless Options!

The Fitness Program provides 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. This 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 plans are eligible to apply. Please see the Wondr video, website, webinars and digital library (PW=expectit) for more information.



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 this plan covers, 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 the same 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. Be sure to call the customer service number on the back for your HMO 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 be required 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. Please view the Health Advocate video for more information.

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. Provider are available 24 hours a day, seven days a week by mobile app, online video or phone.

Instead of going to the office, you can arrange a virtual visit while at home, work or many other places. A virtual visit may cost less than going to an 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, video and website for details.

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

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

LEARN TO LIVE DIGITAL MENTAL HEALTH PROGRAM (PPO PLANS ONLY) | See flyer and video for details.

Click here to return to Table of Contents

Express Scripts Prescriptions

EXPRESS SCRIPTS | CONTACT INFO AND USEFUL LINKS

800.294.7041 | 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 can download Express Scripts prescription drug card to use at the pharmacy when you fill prescriptions. If you prefer a physical ID card, please contact Express Scripts directly.

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, Walgreens, 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, when a generic alternative is 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" and 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®

2025 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

Employee Contributions (Semi-Monthly)	
Single	$2.19
Single + 1	$4.40
Family	$8.54

Maximum Plan Allowances or MPAs:
The highest dollar amount Delta Dental pays for a covered service. Participating providers agree not to charge enrollees the difference (if any) between the MPA and the provider'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 PROVIDER | PPO NETWORK, PREMIER NETWORK, AND NON-NETWORK OPTIONS

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

PPO Network | Lowest out-of-pocket expenses

- PPO network providers 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 provider would typically submit for a claim.
- PPO providers 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 provider compared to a PPO provider. However, you may save more money with a Premier provider compared to a Non-Network provider.
- Premier providers agree to Delta's maximum plan allowances as payment in full, which may be lower than what a provider would typically charge.

Non-Network | Highest out-of-pocket costs

- Non-Network providers 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 provider to predetermine services over $200.

- If your provider 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 provider 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 | CONTACT INFO AND KEY LINKS

800.877.7195 | VSP Website | VSP ID Card | Provider Finder | Plan Overview

2025 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	$0.81
Family	$1.29

Click here to return to Table of Contents

Vision Insurance

MEMBER ACCOUNT

Create an account at 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.

No ID Necessary - Just tell your provider that you have VSP coverage.

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 OFFERS & PROMOTIONS

Visit the Offers page on the VSP website or mobile app for current member extras and savings opportunities.

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

HEALTH INSURANCE OPT-OUT INCENTIVE | PROGRAM DETAILS

If you have access to health insurance through a family member, 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 from the City (as described below), 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.
- 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 your Benefit Enrollment Period:

- Waive medical, dental, and vision coverage through your Employee Portal 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 Human Resources by open enrollment deadline.

HEALTH INSURANCE OPT-OUT INCENTIVE | FORM REQUIREMENTS

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

Opt-out documentation must be provided regardless of previous participation.
All opt-out requests must include proof of coverage under an alternate medical insurance plan.

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 | Beneficiary Designation Form | Plan Highlights & Rates | Life Insurance Calculator

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 BASIC 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 funds the full-cost of this coverage. Employees are responsible for designating beneficiaries and for keeping their 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 cost for supplemental life insurance through payroll deductions. Coverage ceases on your last day of employment.

Eligible employees can enroll in or increase their supplemental life insurance coverage:

- Upon Hire within 30 days (coverage amounts exceeding the guarantee issue amounts, $300,000 employee / $50,000 spouse, require medical underwriting approval).
- During annual open enrollment for employee or spouse coverage (the completion of a health questionnaire and underwriting approval is required).
- For a Family Status Change (the completion of a health questionnaire and underwriting approval is required for spouse coverage and employee coverage exceeding guaranteed issue amounts or where underwriting approval was previously declined).

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.

If you are enrolling outside of your new hire enrollment or a qualified life event, you generally must submit an evidence of insurability questionnaire for underwriting review and approval. *

Click here to return to Table of Contents

Supplemental Life Insurance

SUPPLMENTAL EMPLOYEE AND SPOUSE LIFE INSURANCE

You may request employee and/or spouse supplemental life coverage amounts during open enrollment, upon hire, or with a qualifying life event within the guidelines provided below.

	Coverage Minimum	Coverage Amount	Guaranteed Issue Amount	Coverage Minimum
Employee	$ 10,000	Elected in Increments of $10,000	$ 300,000	$ 750,000
Spouse	$ 5,000	Elected in Increments of $5,000	$ 50,000	$ 500,000

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

- Both supplemental employee and spouse life coverage is based on the employee's age as of the first of the year.
- Employees must enroll in employee supplemental life coverage in order to elect spouse supplemental life coverage. Your spouse's coverage cannot exceed 100% of your combined basic and employee supplemental life coverage.
- Upon hire, employees may enroll in employee and spouse supplemental life coverage, up to the guaranteed issue amounts ($300,000 employee / $50,000 spouse), without providing evidence of insurability requirement.
- During open enrollment, employees currently enrolled in employee supplemental life may increase their coverage by $10,000 without evidence of insurability provided that the resulting amount of insurance does not exceed the $300,000 guaranteed issue limit.
- Other new or increased coverage elections made during open enrollment require the completion of a health questionnaire and underwriting approval.
- Within 30 days of a qualifying life event, employees may enroll in or increase their employee supplemental life coverage, up to the $300,000 guaranteed issue amount, without providing evidence of insurability if they were not previously declined coverage.
- If your spouse is eligible for coverage as a City employee, they cannot be enrolled in spouse supplemental life.
- Only one employee may cover a dependent child.
- Employees pay100% of the premium through payroll deduction.
- Premiums will be deducted from employees' payroll on a semi-monthly basis (1st two pay periods of each month).

MONTHLY COST

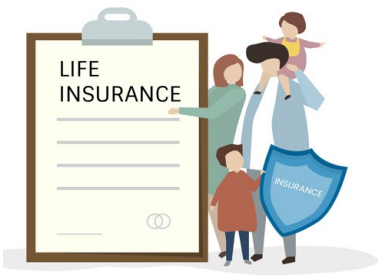
Employee or Spouse Supplemental Life

Employee's Age	Rate per $1,000
<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

Rates increase with age and all rates are subject to change.
Note: Spouse rates are based on employee's age.

FAMILY PLAN (DEPENDENT PACKAGE) LIFE COVERAGE

The Family Plan provides coverage in the amount of $10,000 for your spouse and $5,000 for each eligible child (generally children under the age of 26).



- You can only enroll in this coverage upon hire or during an eligible qualifying life event.
- You cannot elect Family Plan Life coverage during open enrollment .
- The employee pays the full cost of this coverage. The cost is only $0.26 per month regardless of the number of covered dependents. Premiums for this coverage will be deducted directly from employees' payroll on a semi-monthly basis.
- If your spouse is eligible for coverage as a City employee, only your or your spouse can carry this coverage. The plan would cover your eligible children only and not your spouse (City employee).

Click here to return to Table of Contents

Flexible Spending Accounts (FSA)

WEX | CONTACT INFO AND USEFUL LINKS

866.451.3399 | WEX Website | Member Login | Mobile App | Searchable Eligible Expense List

Dependent FSA: Flyer - Video | Medical FSA: Flyer - Video | Contribution Limits | Claims Form

FLEXIBLE SPENDING ACCOUNTS

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

- **Annual Enrollment:** FSA elections are valid for the calendar year only. To participate in 2025, you must enroll during the annual open enrollment period. If you miss the deadline, you won't be able to participate unless you experience a qualifying life event or enroll as a newly hired employee.
- **Payroll Deductions:** Your contributions are deducted from your payroll on a semi-monthly basis (1st two pay periods of each month).

DEPENDENT CARE FSA

A Dependent Care FSA helps you save by setting aside pre-tax dollars for eligible dependent care expenses, such as: Childcare for dependents under 13, elder or adult daycare, or care for disabled dependents.

Important Details:

- **Reimbursement:** You can only be reimbursed up to the amount deducted from your payroll, unlike medical FSAs which are pre-funded.
- **Eligibility:** You and your spouse (if applicable) must be employed full-time, or your spouse must be a full-time student or actively seeking employment.
- **Contribution Limit:** The current maximum contribution is $5,000 for single or married couples filing jointly, and $2,500 for married couples filing separately. 2025 limits are yet to be announced.

MEDICAL FSA

A medical FSA allows you to save pre-tax dollars for eligible out-of-pocket expenses such as medical, prescription, dental, and vision costs.

Key Features:

- **Full Access:** Your entire annual contribution is available on the first day of the plan year.
- **Eligibility:** You and your spouse cannot be actively enrolled in and contributing to a Health Savings Account (HSA).
- **Debit Card:** Program participants receive a WEX debit card to pay for eligible expenses. If you re-enroll, your elected amount will be loaded onto your current card. Contact WEX directly for a replacement if needed.
- **Contribution Limit:** The current maximum annual contribution is $3,200; 2025 contribution limits are yet to be announced.

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.

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

You have until 3/15/2026 to incur eligible expenses against your 2025 FSA contributions and until 3/31/2026 to submit your claims.

Unsubstantiated claims are subject to taxes.

SUBMIT YOUR RECEIPTS!

Click here to return to Table of Contents

ELIGIBLE EXPENSE SEARCHABLE LIST

Did you know that many over-the-counter medical products are eligible for reimbursement through your Medical FSA? Here are a few examples of Medical FSA-eligible items available in the WEX Searchable List.

Use this comprehensive list to explore eligible expenses for both Medical and Dependent Care FSAs. Simply filter the list by plan type—Medical FSA or Dependent Care FSA—to find approved items, programs, and services.

Eligible Expenses

EXPENSE	ELIGIBLITY	PLAN	COMMENTS AND SPECIAL RULES
Allergy Medicine	Eligible	Medical FSA	Examples: Alavert, Claritin, Zyrtec, Loratadine.
Antacids / Acid Controller	Eligible	Medical FSA	Examples: Maalox, Prilosec OTC, Zantac.
Antihistamines	Eligible	Medical FSA	Examples: Benadryl, Claritin, Zyrtec.
Bandages, Elastic or for Torn or Injured Skin	Eligible	Medical FSA	Example: Ace bandages, athletic bandages. Examples: Band-Aid, Curad, butterfly bandages
Blood Pressure Monitor	Eligible	Medical FSA	
Cold Medicine	Eligible	Medical FSA	Examples: Comtrex, Sudafed, Vicks, Nyquil, Dayquil
Contact Lenses, Materials, & Equipment	Eligible	Medical FSA	Contact lenses for solely cosmetic purposes (for example, to change one's eye color) do not qualify
Decongestants	Eligible	Medical FSA	Examples: Dimetapp, Sudafed
Expectorants	Eligible	Medical FSA	Examples: Mucinex, Triaminic, Comtrex, Robitussin
Face Masks, Disposable	Eligible	Medical FSA	
Feminine Hygiene Products	Eligible	Medical FSA	Example: Tampons, Pads, cups
Fever Reducing Medications	Eligible	Medical FSA	Examples: Aspirin, Motrin, Tylenol, Ibuprofen, Acetaminophen
First Aid Kit	Eligible	Medical FSA	
Hand Sanitizer (including anti-bacterial)	Eligible	Medical FSA	Examples: Germ-X, Purell
Lumbar Support Brace	Eligible	Medical FSA	
Nicotine Gum or Patches	Eligible	Medical FSA	Examples: Nicoderm, Nicorette
Pain Relievers	Eligible	Medical FSA	Examples: Advil, Aspirin, Tylenol, Acetaminophen, Ibuprofen
Reading Glasses	Eligible	Medical FSA	
Sunscreen	Eligible	Medical FSA	
Thermometers	Eligible	Medical FSA	

YOUR WEX DEBIT CARD MAKES PURCHASING ELIGIBLE OVER-THE-COUNTER ITEMS EASY

- **Where does it work?** Your WEX debit card is accepted at a wide range of merchants. Specifically, it works at any retailer with an Inventory Information Approval System (IIAS) or those that meet the IRS 90% rule (where 90% of gross sales are eligible expenses). Common IIAS merchants include **Wal-Mart, Target, Walgreens, CVS,** and **Amazon**.

- **How does it work?** At an IIAS merchant, simply swipe your card, and it will automatically approve eligible purchases. If shopping at a non-IIAS merchant, you may need to provide additional documentation.
- **What if additional documentation is required?** If documentation is required, you can easily track claims and upload supporting documents using the WEX mobile app or through your WEX online account.

Click here to return to Table of Contents

Commuter/Transit Benefits

WEX | CONTACT INFO AND USEFUL LINKS

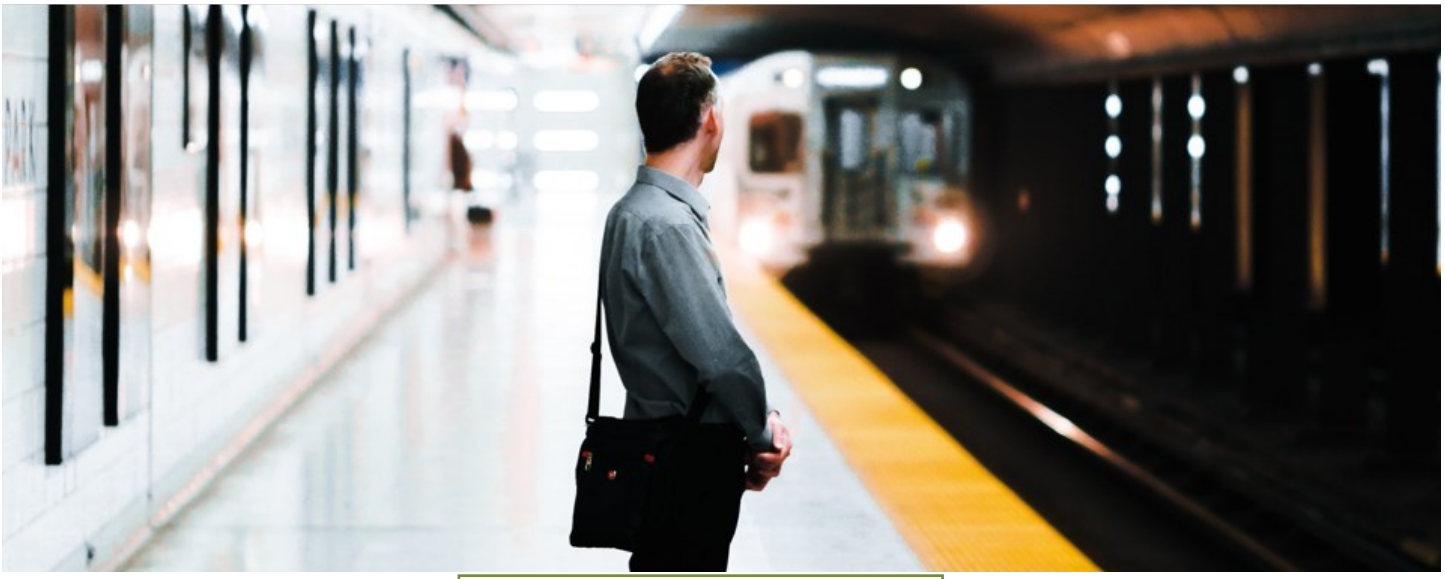
866.451.3399 | WEX Website | Member Login | Mobile App

Commuter/Transit Benefit Flyer | Video

COMMUTER/TRANSIT BENEFITS | MASS TRANSIT AND PARKING

Commuter/Transit benefits let you save on eligible mass transit and parking expenses by setting aside **pre-tax dollars** from your payroll for your daily commute.

- **Enrollment:** You can enroll in commuter/transit benefit at any time, but your elections are only good for the calendar year. You must re-enroll in the program during the City's annual open enrollment period.
- **Adjusting Contributions:** You can adjust your contribution amount on a monthly basis. Simply contact Human Resources to update your election.
- **Funds Availability:** Your funds become available 2–3 days after each payroll contribution, and they roll over month-to-month until used. However, if your employment ends, any remaining funds will no longer be available.
- **Payment Options:** You can either submit receipts for eligible expenses to receive reimbursement or use your WEX debit card to directly pay for qualified expenses.
- **Eligibility:** This benefit applies only to City employees. Commuting expenses for dependents are not eligible under this program.
- **Contribution Limits:** The current maximum monthly contribution for both mass transit and parking is $315. 2025 contribution limits have not yet been announced..



Employee Assistance Program (EAP)

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM | CONTACT INFO AND USEFUL LINKS

833.806.8722 | Guidance Resources Website (Registration Web ID: CODPEAP) | Guidance Resources Overview Video

Services Flyer | First Responder Flyer | You're Not Alone Flyer | What to Expect When Reaching Out Video

ComPsych®
— The GuidanceResources Company® —

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM

The ComPsych employee assistance program is a FREE AND CONFIDENTAL service designed to support the well-being of employees and their household family members. This program offers a wide range of resources for mental, physical, social, and financial health, helping your navigate life's challenges.

- Resources include personalized counseling sessions, self-guided assessments, financial and legal consultations, extensive resource libraries, on-demand training sessions, newsletters, and more.
- Call 833.806.8722 for confidential 24/7 support or visit the Guidance Resources website.

CONFIDENTIALITY IS KEY

Your privacy is paramount. All information shared with EAP counselors is completely confidential and will not be disclosed to your employer or anyone else without your explicit consent.

Services:

Confidential Emotional Support
8 sessions per issue, per year
- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support
- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance
- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more
- Holistic retirement planning to support your financial security as well as your social and emotional transition

Well-Being Support
- Make positive lifestyle changes with one-on-one health coaching session over the phone or via video link
- Improve sleep habits, time management skills, self-compassion
- Get help with burnout, stress, resiliency and more

Interactive Digital Tools
- Self-care platform offers guided health programs
- Tackle anxiety, depression, stress
- Improve mindfulness, sleep, and more

Digital Support
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings
- Schedule counseling, work-life support or other services directly online via the Connect to Care menu

Click here to return to Table of Contents

Employee Assistance Program (EAP)

WHY MIGHT MY FAMILY OR I USE EAP SERVICES?

- There are many reasons to use the EAP. You may wish to contact the EAP if you:
- Are feeling overwhelmed by the demands of balancing work and family
- Are experiencing stress, anxiety or depression
- Are dealing with grief and loss
- Need assistance with child or elder care concerns
- Have legal or financial questions
- Have concerns about substance abuse for yourself or a dependent

GUIDANCE RESOURCES

Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych Guidance Resources program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Topics available on the Guidance Resources website include:

- **WELLNESS** | Wellness is the state of being physically, mentally and emotionally healthy. Maintaining wellness is an ongoing process because everything you do and experience affects your well-being. Staying well reduces stress and illness, and allows you to have positive interactions with others.
- **RELATIONSHIPS** | Family, friends and significant others all play a role in your everyday life and often serve as a form of support. Your lives are interconnected, as their actions affect you and your actions have an impact on them. Relationships require effort to establish and preserve, and it is not uncommon for problems and questions to arise.
- **WORK & EDUCATION** | Receiving an education is essential to obtaining a job and succeeding in the workplace. As your education and career progresses, you will encounter new paths, make important decisions and run into obstacles.
- **FINANCIAL** | Managing finances requires diligence, planning and a firm understanding of financial laws and regulations. Spending and saving involves effective budgeting and a clear idea of future goals and objectives. Encountering ups and downs in finances and financial planning is normal.
- **LEGAL** | Most aspects of everyday life are regulated by laws and rules. Being familiar with legal topics is important, whether you are facing a legal issue or are simply interested in learning more about how a law affects a certain aspect of your life.
- **LIFESTYLE** | Everyone has different interests, routines, preferences and needs. There are many actions you can take to live comfortably and safely, enjoy every day, and ultimately, improve the quality of your life.
- **HOME & AUTO** | Buying a new home or car is a significant decision and requires adequate planning. When making this decision, you will need to consider your own preferences and needs as well as your finances. Once you have bought a home or car, regular maintenance is required.
- **RETIREMENT** | Retire Source addresses employees' personal, financial, legal, emotional, physical and familial concerns about aging and retirement by taking a logical, hands-on and goal-driven approach to help answer questions.

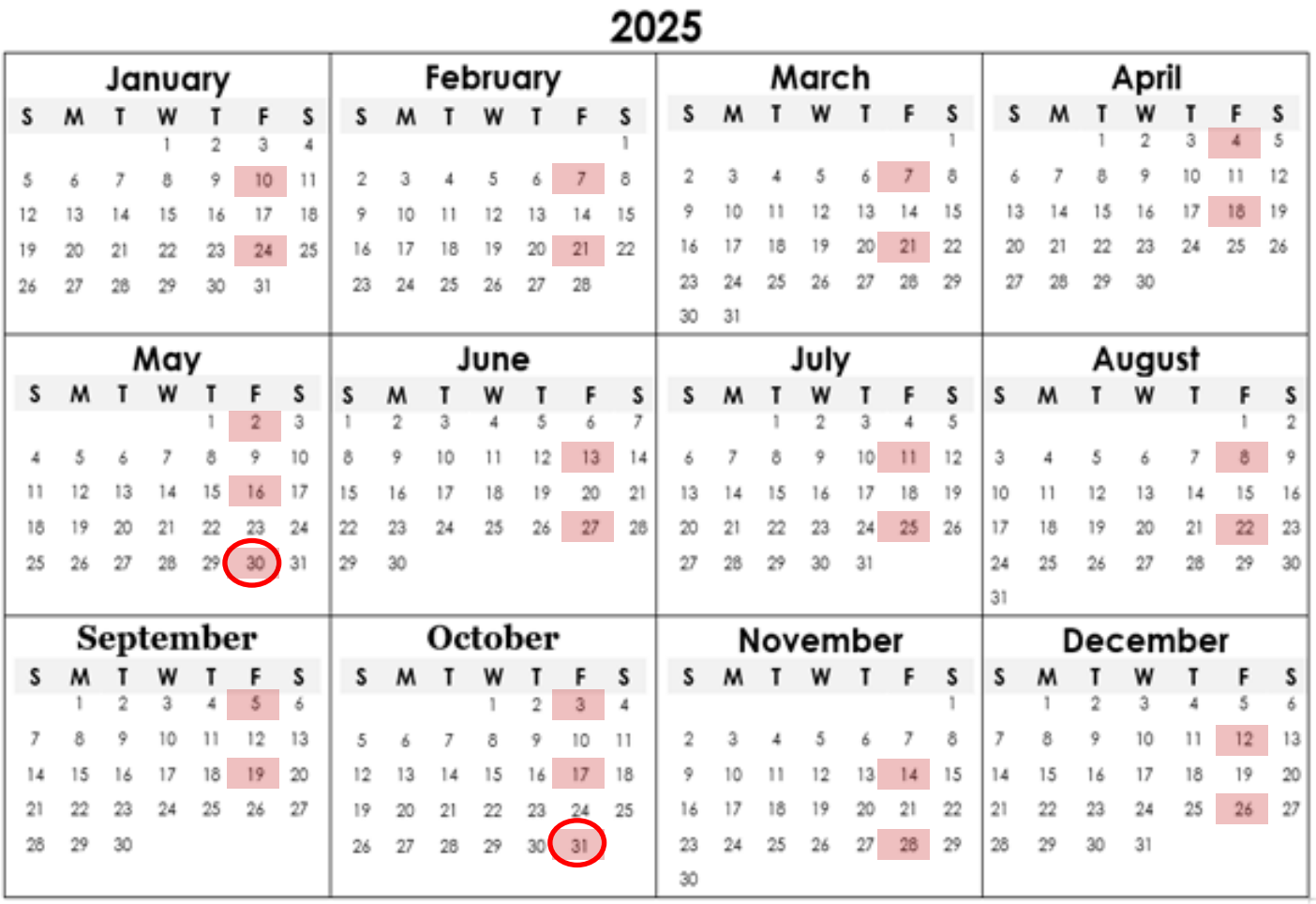
Life is challenging. ComPsych can help.

Confidential 24/7 support.

833.806.8722

Click here to return to Table of Contents

2025 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 • 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 update your benefits, you must make the change within 30 days after the event occurred. If you miss this 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 enrolled in 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. Once you drop a dependent from your retiree coverage, you cannot re-enroll that dependent at a later date.
- 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 the future.
- In retirement, you can switch between HMO, PPO2 and PPO3 plans during annual open enrollment.
- If you are planning on retiring in 2025, ensure your elections are as desired in retirement during open enrollment.

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.

Tim Roberts
Mission Square, Retirement Plan Specialist
202.759.7159 | taroberts@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 member services at 800.275.4673 for your fund distribution options.

Click here to return to Table of Contents

457 Plans

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 not to be enough.

Contributions

- Pre-tax contributions (Federal and state) you make reduce your taxable income for the year.
- These contributions and all associated earnings are not subject to these taxes 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 end your employment with the City. 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 distributed per your wishes and avoid the potential costs and delays of probate.

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
Tim Roberts
Mission Square, Retirement Plan Specialist
202.759.7159 | taroberts@missionsq.org

MissionSquare RETIREMENT

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

Nationwide

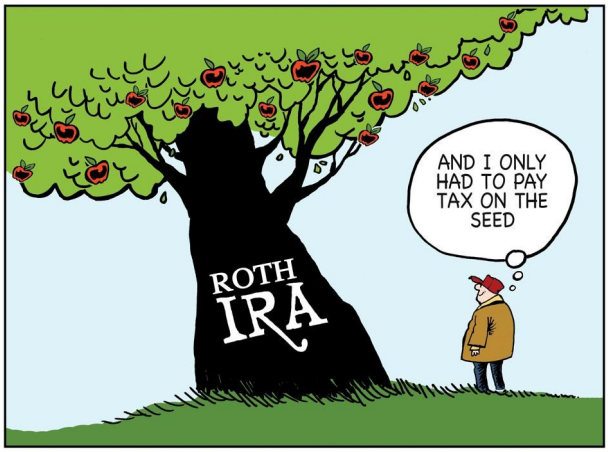
Click here to return to Table of Contents

Roth IRAs and Contribution Limits

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 any time.
- Roth IRAs are subject to specific income limits based on tax filing status. Please be sure to check your eligibility.
- You control how your account is invested, choosing from available options.
- You designate a beneficiary or beneficiaries to receive any remaining assets upon your death.



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
Tim Roberts
Mission Square, Retirement Plan Specialist
202.759.7159 | taroberts@missionsq.org

MissionSquare RETIREMENT

457 PLAN AND ROTH IRA 2024 CONTRIBUTION LIMITS

- 2025 contribution 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	$23.000	$7,500	$23,000
Roth IRA	$7,000	$1,000	N/A

Click here to return to Table of Contents

Retirement Health Savings Program (RHS)

RETIREMENT HEALTH SAVING PROGRAM (RHS)

THE CITY'S RHS PLAN OFFERS AN EXCEPTIONAL OPPORUTNITY TO BUILD RETIREMENT SAVINGS!

This program can play a crucial role in your retirement savings portfolio by helping you prepare for the health care costs experienced in retirement. The program provides a tax-free, cash-value conversion of unused, unpaid leave into funds that can be used for the reimbursement of eligible health care expenses for you and your eligible dependents upon retirement or employment separation.

KEY BENEFITS

- **CASH VALUE FOR SICK LEAVE** | Unused, unpaid sick leave often does not have a cash or cash-value equivalent. The RHS program provides a cash-value payout for eligible unused, unpaid sick leave hours, including sick leave earned through the City's non-absence bonus programs.
- **TAX ADVANTAGED SAVINGS** | The City's RHS plan offers TRIPLE TAX SAVINGS with tax-free contributions, investment earnings, and withdrawals for qualified health care expenses. You NEVER pay Federal, Illinois, Social Security or Medicare Tax on RHS funds!

  Comparison to other retirement savings vehicles: The City's 457 Plan and Traditional IRA withdrawals (as well as regular pensions) are generally subject to Federal tax and sometimes state taxes depending on where you reside. And with Roth IRAs, your contributions are made on income that has already been taxed.

THE CITY'S RHS PLAN OFFERS TRIPLE TAX SAVINGS

1. **Tax-Free Contributions**
2. **Tax-Free Investment Growth**
3. **Tax-Free Withdrawals (for qualified health care expenses)**

- **INVESTMENT CONTROL** | You control how your contributions and associated earning are invested in your Mission Square RHS account. You have the flexibility to make changes at any time, choosing from Mission Square's available investment options.

  Upon initial transfer, your RHS funds are placed in a default investment option. If you participated in the City's RHS program, please be sure to visit your Mission Square member portal to review your investment elections.

PLAN DEFINITIONS

- ELIGIBLE EXPENSES | These include medical, dental, and vision out-of-pocket costs as well as after-tax health care premiums.
- ELIGIBLE DEPENDENTS | These include a spouse and generally children under the age of 27.

UPON DEATH CONSIDERATIONS

- Upon your death, your account can be transferred to your spouse and eligible dependents to use for their eligible expenses.
- If you do not have eligible dependents, your remaining account funds will be reallocated to all City RHS plan participants with an account balance.
    - Per current IRS regulations, your RHS assets cannot be assigned to a non-eligible dependent upon your death.
    - Be sure to plan the use of your RHS funds accordingly.

You can find the City's RHS Plan Provisions on the Current Employee Benefits Page of the City's website.

Click here to return to Table of Contents

Retirement Health Savings Program (RHS)

HOW DOES THE RHS PROGRAM WORK?

- The City's RHS Program actually has two components –**Annual Sick Leave Payout Program** -AND- **Upon Employment Separation Program**. The Non-Management Annual and Upon Separation Programs are detailed below with examples. (Note, management employees' calculations may differ. Please see your applicable collective bargaining agreement or the City's Personnel Policy [non-union] for details.)

	ANNUAL SICK LEAVE PAYOUT PROGRAM NON-MANAGEMENT	UPON EMPLOYMENT SEPARATION PROGRAM
Am I eligible to participate?	**You must accumulate a minimum bank of 90 sick days* to be eligible** *For Police Dept. employees assigned to 12hr shifts, ninety 8hr days/ 720 hours of banked sick time is required to participate *For Fire Dept. employees assigned to 24hr shifts, 45 days/1080 hours of banked sick time is required to participate	**You must have previously participated in the Annual Sick Leave Payout Program with an RHS transfer to be eligible**
What is my eligible leave?	**Eligible Hours = Sick leave hours accrued in excess of 90 days** **EXAMPLE:** You work an 8hr/day schedule and you have a sick leave balance of 100 days/800 hours as of the end of the year • 800 Sick Hours -LESS- 720 Sick Hour (90 days) = 80 Eligible Leave Hours	**Eligible Leave = All remaining unused, unpaid sick, vacation and personal days in your accrual bank as of your last day of employment** **EXAMPLE:** You work an 8hr/day schedule and you have the following leave balances as of your last day of employment • 15 Vacation Days, 3 Personal Days and 95 Sick Days = Eligible Leave
What is the amount of my RHS transfer?	**Eligible hours are multiplied by 75% of your calendar year-end hourly pay rate** **EXAMPLE:** You have a year-end hourly pay rate of $25.00 and 100 eligible hours **Step 1 | Calculate Transfer Rate** • $25.00 year-end hourly pay rate x 75% = $18.75 **Step 2 | Multiply Transfer Rate by Eligible Hours** • $18.75 x 80 eligible hours = $1,500.00 **TOTAL RHS TRANSFER = $1,500.00**	**Vacation and personal days/hours are paid at 100% of your final hourly pay rate; For sick time, the first 45 days* are paid at 25% and any additional days are paid at 75% of your final hourly pay rate** *For Police Dept. employees assigned to 12hr shifts, the first forty-five 8hr days/ 360 hours of banked sick time is paid at 25%. *For Fire Dept. employees assigned to 24hr shifts, the first 22.5 days/540 hours of banked sick time is paid at 25%. **EXAMPLE:** You have a $25.00 final hourly pay rate with the final leave balances listed above **Step 1 | Calculate Vacation/Personal Leave Value** • (15 vacation days x 8hr/day) + (3 personal days x 8hr/day) • 120 vacation hours + 24 personal hours = 144 hours • 144 hours x $25.00 = $3,600.00 **Step 2 | Calculate Sick Leave Value** • (45 days x 8hr/day) x ($25.00 x 25%) +(50 days x 8hr/day) x ($25.00 x 75%) • (360 hours x $6.25) + (400 hours x $18.75) • $2,250.00 + $7,500.00 = $9,750.00 **TOTAL RHS TRANSFER = $13,350.00** ($3,600 + $9,750)
When will my RHS transfer take place?	**Annual RHS transfers generally take place in February or March for the previous calendar year's eligible sick leave**	**Upon separation RHS transfers take place on the payroll following the employee's final payroll with hours worked/approved leave**

Click here to return to Table of Contents

Fire and Police Pension Funds

DES PLANES FIRE PENSION FUND I CONTACT INFO AND USEFUL LINKS

Website I Email: firepension@desplaines.org I 847.827.4892

DES PLANES POLICE PENSION FUND I CONTACT INFO AND USEFUL LINKS

Website I Email: policepension@desplaines.org I 847.827.4804

DES PLAINES
ILLINOIS

Click here to return to Table of Contents

IMRF: Pension, Disability, Death Benefits

ILLINOIS MUNICIPAL RETIREMENT FUND | CONTACT INFO AND USEFUL LINKS

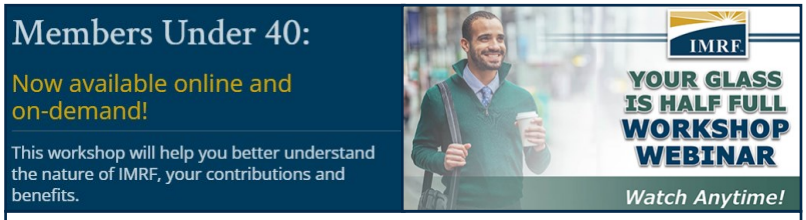
Website | Member Login | Member Services: 800.275.4673

Provides pension/retirement, disability, and death/survivor benefits to employees of local government

- Manage Your IMRF Account With Member Access
- Understanding IMRF Tiers and Plans
- Reciprocal Service
- IMRF Retirement Savings Seminar Presentation Recording | Nov'2023

TIER 1 REGULAR PLAN MEMBERS

- First Participated Before 1/1/2011
- Your Contributions
- Retirement Benefits
- Service Credit
- Pension Options & Refunds at Retirement
- Pension Estimates
- Disability Benefits
- Death and Survivor Benefits



Click Here to View Webinar

Click Here to View Webinar

TIER 2 REGULAR PLAN MEMBERS

- First Participated on or After January 1, 2011
- Your Contributions
- Retirement Benefits
- Service Credit
- Pension Options & Refunds at Retirement
- Pension Estimates
- Disability Benefits
- Death and Survivor Benefits

Click here to return to Table of Contents

IMRF Voluntary Additional Contributions (VAC)

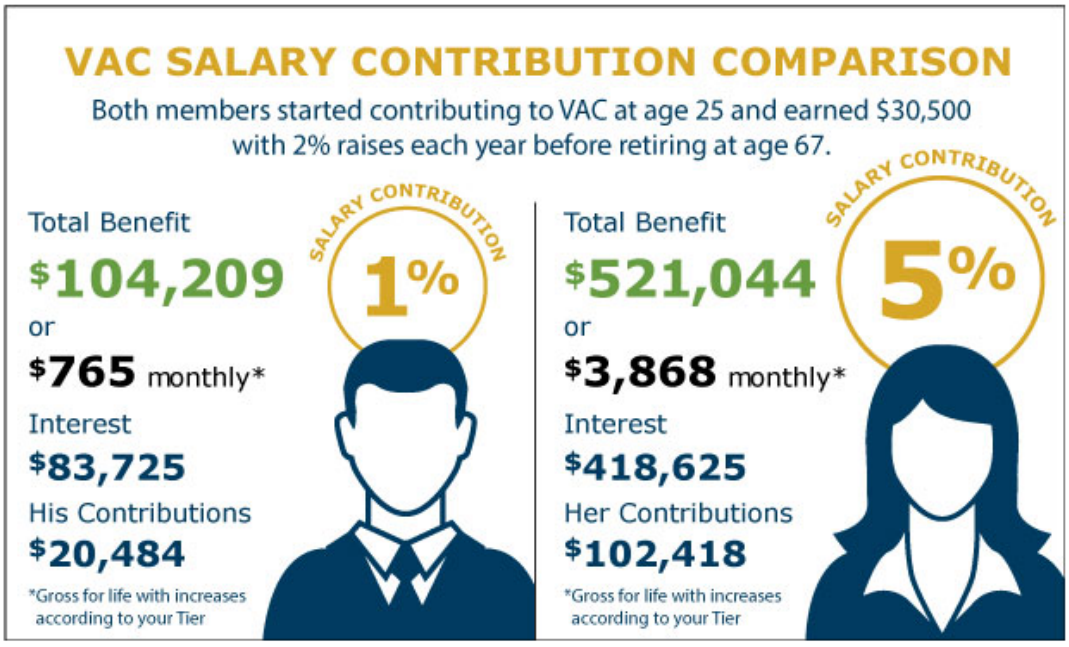
ILLINOIS MUNCIPAL RETIREMENT FUND VAC I CONTACT INFO AND USEFUL LINKS

Tier 1 VAC Plan Overview | Tier 2 VAC Plan Overview | VAC Form | IMRF Website | Member Services: 800.275.4673

IMRF'S VAC PROGRAM IS AN EASY WAY TO HELP YOU SAVE ADDITIONAL RETIREMENT INCOME

- Tier 1 members (first participated before 1/1/2011) may contribute up to a maximum of 10% of your IMRF reportable earnings through payroll deductions.
- Tier 2 members (first participated on or after 1/1/2011) 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.



Click here to return to Table of Contents

IMRF Voluntary Additional Contributions (VAC)

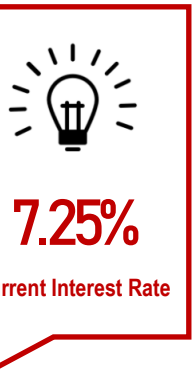
RETIRING WITH VOLUNTARY ADDITIONAL CONTRIBUTIONS

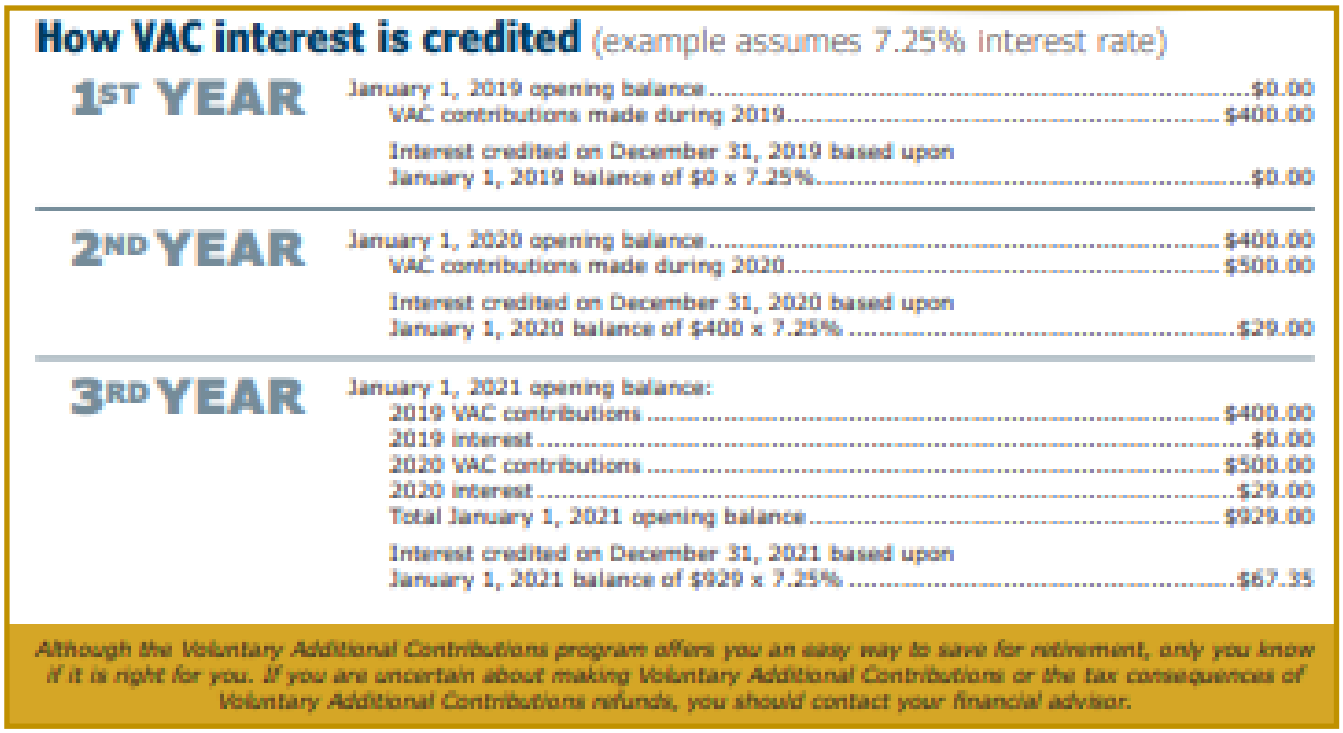
If you leave your VAC on deposit until you retire from IMRF, at retirement, you may choose to receive your Voluntary Additional Contributions as either:

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

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 interest in 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. 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.





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

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