2023 Plan Year

Your Benefits, Your Choice

Employee Benefits Guide

Medicare D Coverage Disclosure is Located on Page 17.

*Please retain this booklet for future reference.

BENEFIT HIGHLIGHTS

- Health Insurance
- Dental Insurance
- Vision Insurance
- Flexible Spending Accounts
- Health Savings Account
- Annual Required Notices

WELCOME TO YOUR EMPLOYEE BENEFITS!

We understand your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. Within this guide, you will find the highlights of the benefits offered by the City.

OPEN ENROLLMENT for Current Employees is 11/06/2022 – 11/21/2022 for the 2023 Plan Year

ALL eligible employees should submit enrollment forms this year. However, if you take no action during your open enrollment period, your current benefit elections will roll over—**with the exception of your Flexible Spending Accounts and Health Savings Accounts**. Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

If you were hired September or October and just enrolled in benefits, you will still need to make your benefit elections for 2023.

New Employees hired on or after November 2, 2022

You will have 30 days to make your benefit elections for 2023.

CONTACTS

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE/EMAIL
Medical	UMR	(800) 826-9781	www.umr.com
Dental	UMR	(800) 826-9781	www.umr.com
Vision	Superior	(800) 507-3800	www.superiorvision.com
Flexible Spending Account (FSA)	UMR	(800) 826-9781	www.umr.com
Health Savings Account (HSA)	UMR through Optum Bank	(866) 234-8913	hsagroup@optumbank.com

The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description on the City's SharePoint or from the Human Resources Department.

ELIGIBILITY & ENROLLMENT

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits, as well as qualified retirees and survivors, active Mayor and City Council Members; and qualified employees of the Library and the Township & Assessor's Office.

As a new employee, you have 30 days from your initial start date to enroll in benefits. Benefits will take effect the first of the month following 30 days of employment.

Partner Eligibility

The employee's legally married Spouse or qualified Domestic Partner, provided there is no legal separation.

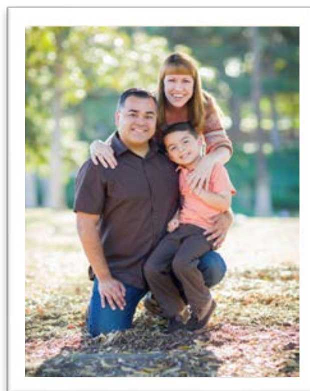
Child(ren) Eligibility

The employee's dependent children, legally adopted children or grandchildren from the date the employee assumes legal responsibility, children or grandchildren for whom the employee has legal guardianship, and stepchildren; until the end of the month in which they attain age 26.

Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.

Any child who has been honorably discharged from military service is covered to age 30, but must be living in the state of Illinois. There may be an additional premium charged for this coverage.

Also included are the employee's children age 26 or older who are mentally or physically disabled and totally dependent on the employee for support. To be eligible for this continued coverage, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.



Open Enrollment Meetings

<u>11/07/2022</u>
7 am - Noon — Fire Central
1:30 – 5 pm — 505 NE Monroe

<u>11/08/2022</u> — **For Police, ECC & IS only*
7 am – Noon — Police Department
2 pm – 5 pm — Command Post
600 SW Adams

<u>11/09/2022</u>
7 am – 10 am — Public Works
3505 N Dries Lane

<u>11/09/2022</u>
11 am – 1 pm — Library North Branch
Seminar Room
3001 W Grand Parkway

<u>11/09/2022</u> — Library Main Branch
2 pm – 4 pm — Auditorium (L26)
107 NE Monroe

<u>11/10/2022</u>
8 am – Noon — City Hall, Room 106
419 Fulton Street

The decisions you make during enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

Open enrollment runs November 6 through November 21, 2022. The benefits you choose during open enrollment will become effective Jan. 1, 2023.

How to Make Changes

Unless you experience a qualifying life event, you cannot make benefit changes until the next open enrollment period. Qualifying life events include things like:

- **Marriage, divorce, legal separation or death of a spouse**
- **Birth or adoption of a child**
- **Change in child's dependent status**
- **Death of a child or other qualified dependent**
- **Change in employment status or a change in coverage under another employer-sponsored plan.**

<u>You must notify the benefits department of any changes within 31 days of the qualifying event and must provide proof of the qualifying event.</u>

CITY EMPLOYEES and ELECTED OFFICIALS
MEDICAL / DENTAL
EMPLOYEE CONTRIBUTION RATES

UMR Low Deductible Plan

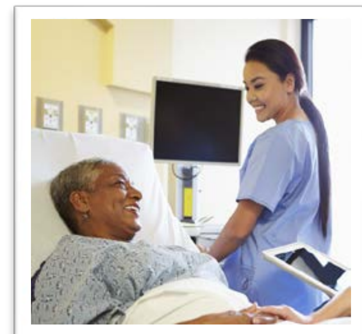
MEDICAL / DENTAL COVERAGE	Monthly	Semi-Monthly	Bi-Weekly
Member Only	$103.38	$51.69	$47.71
Member + Partner	$352.78	$176.39	$162.82
Member + Child(ren)	$279.12	$139.56	$128.82
Member + Family	$487.16	$243.58	$224.84

UMR High Deductible Plan

MEDICAL / DENTAL COVERAGE	Monthly	Semi-Monthly	Bi-Weekly
Member Only	$51.70	$25.85	$23.86
Member + Partner	$176.40	$88.20	$81.42
Member + Child(ren)	$139.56	$69.78	$64.41
Member + Family	$243.58	$121.79	$112.42

PEORIA PUBLIC LIBRARY EMPLOYEES
MEDICAL / DENTAL EMPLOYEE CONTRIBUTION RATES

MEDICAL / DENTAL COVERAGE	UMR Low Deductible PPO Plan	UMR High Deductible PPO Plan
Member Only	$59.64	$53.56
Member + Partner	$125.24	$112.47
Member + Child(ren)	$107.35	$93.40
Member + Family	$172.96	$155.34



HEALTH INSURANCE

UMR – United Healthcare Choice Plus Network

The City provides employees the option to purchase affordable medical coverage. The below plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Create a login at www.umr.com with your Member ID and the Group Number found on your UMR Card. From there you can search providers, see your explanation of benefits and claims experience, verify your deductible and out of pocket balance, and more!

Preventive Care at NO COST to you!

- Annual wellness exam
- Routine/Preventive labs
- Immunizations
- Mammograms
- Colonoscopy screening (age 50+)
- Routine annual PAP for women
- Routine Annual PSA test for men

Below are highlights of both the Low Deductible and High Deductible plans.
*Some Services require Pre-approval or Medical Management, and some services have limits to the number of visits – *this list does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits.*

HEALTH COVERAGE HIGHLIGHTS	UMR **Low Deductible PPO Plan**		UMR **High Deductible PPO Plan**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$1,250	$4,000	$4,400	$10,000
Family	$2,500	$8,000	$8,800	$20,000
Coinsurance (percent paid after you reach your annual deductible)				
Plans Pays	80%	50%	100%	100%
You Pay	20%	50%	0%	0%
Annual Out-of-Pocket Maximum				
Individual	$4,000	$10,000	$4,400	$10,000
Family	$8,000	$10,000/person	$8,800	$20,000
Covered Services – Preventive Care ****Must be billed as Wellness/Preventive, not Diagnostic – be sure your doctor's office codes it accordingly***				
• Preventive/Routine Physical Exams at Appropriate Ages (Sports physicals are not covered) • Preventive/Routine Labs • Immunizations, including Vaccines for Shingles (age 50+); and flu • Preventive Mammogram, including 3D • Preventive/Routine Annual PAP Smear • Preventive/Routine Annual PSA Test • Colonoscopy Screening (age 50+) • Sigmoidoscopy Screening (age 40+) • Annual Vision Screening Exam, including refraction with routine diagnosis	No Charge; Deductible Waived	50% coinsurance	No Charge; Deductible Waived	

HEALTH COVERAGE HIGHLIGHTS *Covered Services*	Low Deductible PPO Plan		High Deductible PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Primary Care Office Visit	$25 copay /visit; Deductible Waived	Subject to Deductible	Subject to Deductible	
Specialist Office Visit ***Including Psychiatrist, Psychologist***	$50 copay/visit; Deductible Waived	Subject to Deductible	Subject to Deductible	
Teledoc Virtual or Telephonic Visit	$25 copay/visit; Deductible Waived		Subject to Deductible	
Urgent Care	$25 copay/visit; Deductible Waived	50% coinsurance	Subject to Deductible	
Emergency Room	$150 copay/visit; Deductible Waived	$150 copay/visit; Deductible Waived	Subject to Deductible	
Hospitalization	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Outpatient Services	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Durable Medical Equipment (Over $1,000 required pre-approval)	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Hospitalization • Pre-admission Testing • Inpatient Services, including Inpatient Physician Charges, Surgery Services, Hospital Care	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Outpatient Services & Physician Charges • Outpatient Lab and X-Ray Charges • Outpatient physician surgery services • Advanced Imaging	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Extended Care Facility, such as Skilled Nursing, Convalescent or Subacute Facility	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Home Health Care (periodic visit by Qualified Nurse, Therapist, or Dietician, or up to 4 Hours of Home Health Care Service)	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Hospice Care Services and Bereavement Counseling	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Maternity: Routine Prenatal Services	No Charge, Deductible Waived	50% coinsurance	No Charge, Deductible Waived	
Maternity: Non-Routine Prenatal Services, Delivery & Postnatal Care	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Mental Health, Substance Use Disorder, and Chemical Dependency – Inpatient and Residential Treatment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Oral Surgery	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Sterilizations	No Charge, Deductible Waived	50% coinsurance	No Charge, Deductible Waived	
Temporomandibular Joint Disorder Benefits	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Therapy Services (Physical, Occupational, Speech, Cognitive) Limited to 30 visits/plan year – additional visits require medical management approval	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	
Chiropractic Care Limited to 25 visits/plan year – additional visits require medical management review based on Chiropractic Designation and Procedure Code	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Subject to Deductible	

PRESCRIPTION MEDICATIONS

CVS/Caremark

While CVS/Caremark administers the City's prescription plan, Members may use any participating network pharmacy, such as CVS, Walgreens, Hy-Vee, Kroger, Wal-Mart, etc. For a complete list of participating pharmacies near you, log on to www.caremark.com or call CVS/Caremark customer service at (866) 905-6237.

PRESCRIPTION DRUG COVERAGE HIGHLIGHTS	**UMR Low Deductible Plan CVS/Caremark Network**	**UMR High Deductible Plan CVS/Caremark Network (after medical deductible is met)**
Prescription Drug Out of Pocket Maximum	$2,900 Single $5,800 Family	$1,850/Single $3700/Family
Tier 1 Generics	$5/month	$5/month
Tier 2 Preferred Brands	20% of discounted cost/month ($50 max)	20% of discounted cost/month ($50 max)
Tier 3 Non-Preferred Brands	40% of discounted cost/month ($100 max)	40% of discounted cost/month ($100 max)
Tier 4 – Specialty Drugs	30% co-insurance if not enrolled in PrudentRx	Retail copay as noted above

Please note that in the City's High Deductible Plan, Members must pay 100% of the discounted cost for all prescriptions until the deductible has been met. Once the deductible is met, the Member will have access to the tiered co-pays shown above.

All Members should note that if a Preferred Brand is chosen when there is a Generic available, that Preferred Brand will not be covered. The only exception to this is when there is a medical necessity with physician documentation to utilize the Preferred Brand over the Generic. For a complete list of medications in the CVS/Caremark Formulary, log in to www.caremark.com. The 2023 Formulary will be updated on or after 1/1/23.

Prudent Rx - for those enrolled in the Traditional PPO Plan ONLY – The PrudentRx Copay Program assists members by helping you enroll in manufacturer copay assistance programs. Medications in the Specialty tier will be subject to a 30% co-insurance. However, enrolled members who get a copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Retail 90 Program. Members can purchase a 90-day supply of maintenance medications at local retail pharmacies that participate in the Retail 90 program, but they must have a prescription from their physician for a 90-day supply.

Clinical Prior Authorization. Some prescriptions, such as ADHD medication for those over 19, Anabolic Steroids, Anti-fungals, Anti-obesity, Insomnia and Migraine Medications, require authorization before the prescription can be dispensed. In these instances, the pharmacy and Member's physician will work together to complete necessary paperwork for review. This process can take 24 – 72 hours. Annual approval is needed for medications in this category.

Step Care Therapy Program. Several categories of prescriptions are part of the Step Care Therapy Program, which requires the Member to try an over-the counter product or alternative prescription first. These include Anti-inflammatory medications such as Celebrex, Proton-Pump Inhibitors (such as Aciphex, Axid, Nexium, Prevacid). Annual approval is needed for medications in this category.

Prescriptions at No Cost to Member. The following medications are covered at no cost to the Member: Flu Vaccine, Shingles Vaccine (Shingrix (age 50+) and Zostavax (age 60+), pre-colonoscopy preps, oral contraceptives

Specialty Pharmacy Medications. Certain medications must be obtained through the CVS Specialty Pharmacy. You can reach the CSV Specialty Pharmacy by calling 866-295-2779 from 6:30 a.m. – 8:00 p.m. Monday through Friday.

FAMILY ADVANTAGE HEALTH PLAN (FAHP)

Plan Benefits

There are several benefits of the FAHP:

- Reimbursement of any copays, deductibles, and coinsurance due on primary health insurance plan, up to the annual out-of-pocket maximums allowed by the Affordable Care Act. Effectively, this creates a **100% coverage plan** for most participants enrolled in the FAHP.
- No premium contribution deducted from employee's paycheck to enroll in the FAHP.
- Ongoing monthly payroll bonus of $50 per member enrolled in FAHP to help offset any additional premium costs of alternative employer coverage.

Explore Your Options

Think outside the box! The City of Peoria offers the Family Advantage Health Plan option.

Eligibility Criteria

To be eligible, the member[1] (e.g. employee, spouse, and/or child) must meet two criteria:

1. Member has been enrolled on the company medical plan for at least 12 months prior to the FAHP effective date.[2]
2. Member has access to enroll in alternative employer-sponsored medical plan (e.g. via spouse, parent, 2nd job, etc.).

[1] Each member is individually eligible for the plan if they meet the eligibility criteria (i.e. spouse and children can enroll without employee).

[2] New employees must satisfy eligibility requirements, which will be evaluated annually at FAHP open enrollment.

IRS Rules

If eligible for the FAHP, it is important that you comply with IRS rules:

1. You may be enrolled in a Health Reimbursement Account (HRA) or Flexible Spending Account (FSA). However, you cannot be reimbursed from both the FAHP and your HRA or FSA.
2. Employees are not eligible for the FAHP if their alternate coverage:
   - has an active contribution to a Health Savings Account (HSA) – you can deny these contributions and then participate in FAHP; or
   - is Medicare, Medicaid, Tricare, an Individual Policy, a Limited Benefit Health Plan, or any non-employer-sponsored insurance.

How to Enroll

If you are interested in the FAHP, here is what to do next:

1. Verify eligibility for the FAHP with your HR department.
2. Evaluate current coverage vs combination of other employer alternative coverage + FAHP. Use BCC Cost Comparison worksheet.
3. Enroll applicable members in alternative employer coverage. Ensure no HSA dollars are received or contributed if the alternative employer coverage is an HDHP.
4. Waive coverage on the City of Peoria's medical plans for next year and complete the FAHP enrollment and attestation forms.

When to Enroll

Eligible members may enroll in the FAHP:

1. During annual open enrollment period, as long as other employer coverage has same open enrollment period or allows mid-year enrollment;[3] or
2. Due to a qualifying event, such as spouse's open enrollment or change in status (e.g. marriage, birth of child, etc.).

[3] **Note:** If the other employer-sponsored option has a different open enrollment period, try to request mid-year enrollment or you will have to wait until their open enrollment to waive the City's medical plan, enroll in your alternative coverage, and enroll in FAHP at that time.

Premium Payroll Bonus

Your payroll bonus is calculated by the number of family members enrolled (including yourself, if also enrolled) in the FAHP, multiplied by $50 to get to a monthly bonus amount earned. This bonus is paid via standard payroll earnings and is considered taxable income. Payments start first period after your FAHP effective date.

Submitting & Receiving Claims Reimbursement

For point-of-service payments (i.e. copays), present your FAHP Debit Card to the provider and they will swipe the card to cover costs immediately. For other payments, you will receive an Explanation of Benefit (EOB) statement from the carrier—keep these in case of verification.

If you do not pay your bill with your FAHP Debit Card, complete the following steps:

1. Make a copy of the EOB and attach it to your completed Reimbursement Form.
    - Reimbursement Forms are available on My SmartCare, from your HR Department, or at www.benxcel.com.
    - A separate claim form must be filled out for each patient.
2. Submit your completed Request for Reimbursement Form and the claim substantiation to BCC:
    - Online through My SmartCare via the BCC SmartCare app or www.mywealthcareonline.com/bccsmartcare; by
    - Email: bcc-claims@benXcel.com; or
    - Mail: Benefit Coordinators Corporation
Attn: Claims
Two Robinson Plaza, Suite 200
Pittsburgh, PA 15205
3. Once received, BCC will process and substantiate the claim for reimbursement, sending you payment via check or direct deposit.

Questions

BCC has a dedicated team of advisors to help answer any questions you have.

Pre-Enrollment

Submit questions, including the name of the organization you work for, to either of the following:

- Email: customersupport@benXcel.com
- Call: (412) 446 4651

BCC will review your questions, compile answers and ensure you get informed either directly or through group education.

Post-Enrollment

Advisors are available to assist you with your needs, including:

- Filing or receiving claims reimbursements
- Premium payroll bonus issues
- Debit card questions
- Anything related to FAHP Benefits

BCC Customer Service Center:

- Call:1-800-685-6100
M-TH: 8 am – 8 pm (ET), 5 am – 5 pm (PT)
F: 8 am – 6 pm (ET), 5 am – 3 pm (PT)
- Email: bcc-claims@benXcel.com

DENTAL INSURANCE

UMR – No Network

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and x-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Please note that to maintain the full level of coverage, you MUST have at least one preventive care visit yearly. Failure to do so will lessen your overall benefit coverage the following year.

This plan does not have a network, so you can see any dentist you choose. Please keep in mind that your Coinsurance is based on Usual, Customary and Reasonable (UCR) fees. In addition to the Coinsurance, you pay any charges in excess of the UCR amount.

For a complete list of your benefits, please refer to your Dental Insurance Summary Plan Description.

DENTAL COVERAGE HIGHLIGHTS	In-Network (See plan documents for out-of-network coverages)
Annual Deductible	Individual - $150 Family - $300
Annual Benefit Maximum (Individual) (includes Orthodontia Services, excludes Preventive Care Services)	$2,000
General Anesthesia / IV Sedation, as well as for dependents age 4 or younger and in conjunction with oral surgical procedures	$2,000
Preventive Care • Oral exams, cleanings (2 per calendar year) • Fluoride Treatments (2 per calendar year, under age 18 only) • Sealants on teeth 1, 2, & permanent molars (once every 36 months, under age 15 only) • Full Mouth X-Rays (once every 2 years) • Bitewing X-Rays (4 per calendar year)	$0 co-pay, Deductible Waived
Basic Services • Appliances for Bruxism (grinding of teeth) – occlusal guards • TMJ Disorder (appliances for treatment of TMJ covered under Medical Plan) • Filling, Simple Extraction, Root Canal • Oral Surgery • Endodontic Procedures • Denture Repairs and Adjustments after first 6 months from obtaining dentures	Subject to Deductible, then 20% coinsurance
Major Services • Porcelain Crowns (except when in place of a tooth behind the 2nd bicuspid) • Porcelain Veneered Crowns • Bridges, Inlays, Onlays • Full and Partial Dentures	Subject to Deductible, then 50% coinsurance
Orthodontia Services	Subject to Deductible, then 50% coinsurance

NOTE: An Alternative Services Provision applies to all dental procedures, which means if two or more services are considered to be acceptable to correct the same dental condition, the benefits payable will be based on the covered expenses for the least expensive service.

VISION INSURANCE

Superior Vision – National Network

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. The City's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Visit www.superiorvision.com and create a login to view your benefits, print an ID card, and find in-network providers. For a complete list of your in-network and out-of-network benefits, please refer to your Vision Insurance Summary Plan Description.

VISION COVERAGE HIGHLIGHTS	In-Network Co-Pay		Out-of-Network	
Exam Once every 12 months (based on date of service)	$10		$37	
Lenses Once every 12 months (based on date of service)	Single Vision Bifocal Trifocal Lenticular	$25	Single Vision Bifocal Trifocal Lenticular	$28 $40 $53 $84
Frames Once every 24 months (based on date of service) (You pay the difference for frames above Max Benefit)	$0 ($150 max benefit)		$0 ($70 max benefit)	
Contact Lenses Once every 12 months (based on date of service); in lieu of lenses/frames glasses (You pay the difference for lenses above Max Benefit)	Prescribed Contacts - $0 copay ($150 max benefit) Fit & Follow Up - $30 copay		Elective Fit & Follow Up Medically Necessary	$100 Included $210

Maximum out-of-pocket for lens add-ons *Premium, Brand, or Progressive Lenses may have additional charges	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
UV coat	$15	$15
Tints, solid or gradient	$25	$25
Anti-reflective coat	$50	$50
High index 1.6	$55	20% off retail
Photochromics	$80	20% off retail

Monthly Rate (First check of the month)

VISION COVERAGE	Monthly
Member	$6.19
Member + Partner	$12.38
Member + Child(ren)	$14.61
Member + Family	$22.37

FLEXIBLE SPENDING ACCOUNTS (FSA)

UMR

*The Health Care Flexible Spending Account is available to City and Library employees (not Township) enrolled in the **Low Deductible PPO Plan**.*

*Dependent Care FSA is available to City and Library employees (not Township) enrolled in both the **High and Low Deductible Plans.***

Even if you signed up for Health Care and/or Dependent Care FSA in 2022, you MUST re-enroll for 2023.

Mid-year contribution changes can only be made with a Qualifying Event, and Benefits must be notified within 30 days of the event.

What Are the Benefits of a **Health Care FSA**?

Paying for health care can be stressful. That's why the City offers an employer-sponsored FSA. There are a variety of different benefits of using an FSA, including the following:

- **It saves you money**. You can put aside money tax-free to be used for qualified medical, dental and vision expenses.
- **It's a tax-saver**. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use these FSA funds at any time, even if it's the beginning of the year.

You should only contribute the amount of money you expect to pay out of pocket that year. You are able to carry over up to $610 from the prior Plan Year to be used in the current Plan Year. **The current annual maximum amount you may contribute to a Health Care FSA is $3,050.**

What Is a **Dependent Care FSA**?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. **The maximum amount you may contribute each year to a Dependent Care FSA is $5,000 (or $2,500 if married and filing separately).**

FSA Case Study

Because FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money. *Bob and Jane's combined gross income is $30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,500 in medical expenses in the next plan year, they decide to direct a total of $3,050 (the maximum allowed amount per individual, for that taxable year) into their FSAs.*

	Without FSA	With FSA
Gross income	**$30,000**	**$30,000**
FSA contributions	$0	(-$3,050)
Gross income	$30,000	$27,250
Estimated taxes		
Federal	(-$2,550*)	(-$1,776*)
State	(-$900**)	(-$809**)
FICA	(-$2,295)	(-$1,913)
After-tax earnings	**$24,255**	**$22,453**
Eligible out-of-pocket medical expenses	(-$3,500)	(-$450)
Remaining spendable income	**$20,755**	**$22,003**
Spendable income increase	--	**$1,248**

**Assumes standard deductions and four exemptions. **Varies, assumes 3 percent. This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.*

HEALTH SAVINGS ACCOUNT (HSA)

Optum Bank

Available to City and Library employees enrolled on the ***High Deductible PPO*** *(not available to Township employees)***.** Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

Even if you signed up for the HSA in 2022, you MUST re-enroll for 2023.

Mid-year changes to contribution elections can be made at any time throughout the year.

Eligibility requires enrollment in the City's High Deductible PPO and that you and your covered dependents have no other medical coverage.

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money.** Lower monthly premiums, mean less money is being taken out of your paycheck.
- **It is portable.** The money in your HSA is carried over from year to year and is yours, even if you leave the City.
- **It is a tax-saver.** HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

HSA Contribution Limits

The City contributes $500 to the HSA accounts of City employees in January (a pro-rated amount will be contributed to newly hired City employees). 2023 maximum contributions are $3,850 for single and $7,750 family. This includes the $500 contribution from the City.

	City Employees	Library Employees
Member Only	**$3,350**	**$3,850**
Member +Partner, +Children, +Family	$7,250	$7,750
ADDITIONAL Catch-Up Contribution (available to those age 55 or older)	$1,000	$1,000
City Contribution (prorated quarterly for new hires)	$500	

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA in addition to the City's $500 contribution. His plan's annual deductible is $1,250 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1	
HSA Balance	$1,500
Total Expenses: - Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$1,350
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Year 2	
HSA Balance ($1,350 + $1,500)	$2,850
Total Expenses: - Office visits: $100 - Prescription drugs: $200 - Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$2,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

IN-NETWORK VS OUT-OF-NETWORK

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Getting the Most Out of Your Care

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even through the primary physician is in-network.

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

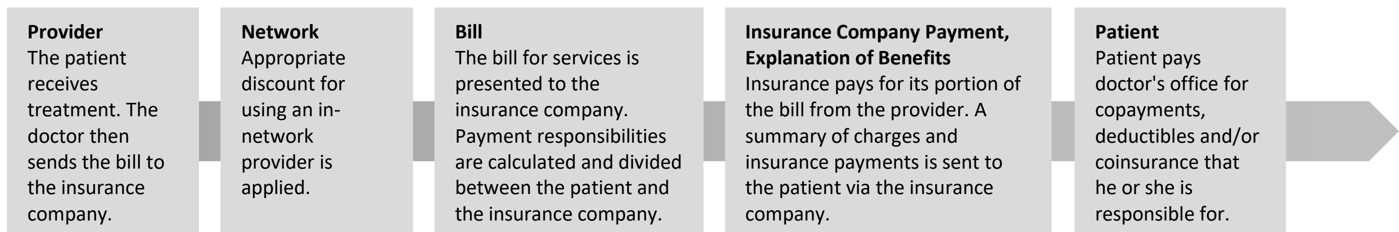
Preventive Care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

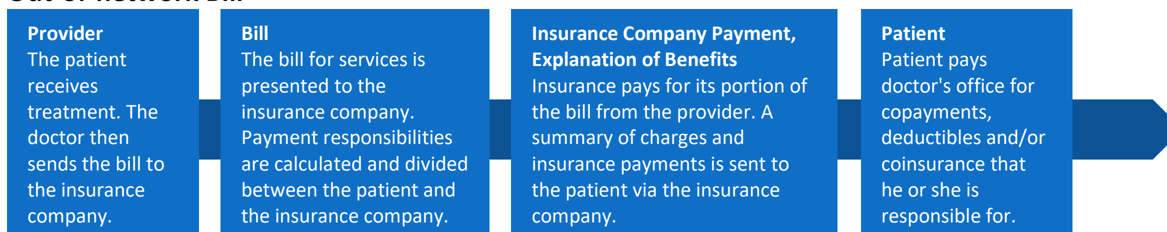
Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

It is very important that you make sure your medical provider is coding your preventive care as preventive / wellness and not diagnostic. Anything coded diagnostic will be subject to deductibles and copays.

In-network Bill



Out-of-network Bill



BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

Annual limit—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.

Claim—A bill for medical services rendered.

Cost-sharing—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.

Coinsurance—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
Example: John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80 percent of the remaining cost, for a total of $2,400. John will still be responsible for 20 percent, or $600, of the remaining cost. The total John must pay for his second surgery is $800.

Copayment (copay)—A fixed amount you pay for a covered health care service, usually when you receive the service.

Deductible—The amount you owe for health care services each year before the insurance company begins to pay.
Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.

Dependent Coverage—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.

Explanation of Benefits (EOB)—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.

Group Health Plan—A health insurance plan that provides benefits for employees of a business.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Inpatient Care—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.

Insurer (carrier)—The insurance company providing coverage.

Insured—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.

Open Enrollment Period—Time period during which eligible persons may opt to sign up for coverage under a group health plan.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Out-of-pocket Maximum (OOPM)—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.

Outpatient Care—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.

Policyholder—The individual or entity that has entered into a contractual relationship with the insurance carrier.

Premium—Amount of money charged by an insurance company for coverage.

Preventive Care—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.

Provider—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.

Qualifying Life Event—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.

Qualified Medical Expense—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

Summary of Benefits and Coverage (SBC)—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

ACA—Affordable Care Act

CDHC—Consumer driven or consumer directed health care

CDHP—Consumer driven health plan

CHIP—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.

CPT Code—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.

FPL—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.

FSA—Flexible spending account. An employer-sponsored savings account for health care expenses.

HDHP—High deductible health plan

HMO—Health maintenance organization

HRA—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.

HSA—Health savings account. A tax-advantaged savings account that accompanies HDHPs.

OOP—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.

PCE—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.

PPO—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.

QHP—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

City of Peoria Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2022. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or
www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll-free number for the HIPP program:
1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565 ❖

Patient Protection Notice

If the City of Peoria Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to

provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.61% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The City of Peoria Group Medical Plan (the "Plan"), which includes medical dental and flexible spending account coverages offered under the City of Peoria Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures City of Peoria has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan

may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation: As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

City of Peoria is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may

request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at City of Peoria, 419 Fulton St, Ste 200, Peoria IL 61602, 309.494.8500. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from City of Peoria Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Peoria and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you

should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Peoria has determined that the prescription drug coverage offered by the City of Peoria Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of Peoria coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Peoria coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of Peoria and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Peoria changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/10/2022
Name of Entity/Sender: City of Peoria
Contact--Position/Office: Human Resources
Address: 419 Fulton St, Ste 200, Peoria IL 61602
Phone Number: 309.494.8500 ❖