



CITY OF  
PEORIA

2026 | Active Employees

# Benefits Guide



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**Disclaimer:** 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 from the Human Resources Department.

# Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

## When to Enroll

- **Current Employees:** Open enrollment is from November 10 to November 21, 2025, for the 2026 Plan Year. This is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** If you were hired on or after November 1, 2025, you will have 30 days to make your benefit elections for 2026. If you were hired in September or October and just enrolled in benefits, you will still need to make your benefit elections for 2026.



### Enroll online through Employee Self Service!

Scan QR code or visit  
<https://selfservice.peoriail.gov/ess>

## When to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

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



### Medicare Part D Notice:

If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **25-Error! Bookmark not defined.** for details.

# New This Year!

## Benefit and Cost Changes for 2026

Benefit changes take effect on **01/01/2026**.



### Working Spouse Surcharge

- To help manage rising healthcare costs and ensure our medical plan remains sustainable for everyone, we are introducing a **working Spouse Surcharge** beginning 01/01/2026.
- If your spouse has access to medical coverage through their own employer but chooses to enroll in our plan instead, a monthly surcharge of \$150 will apply.
- Consider enrolling in the **Family Advantage Health Plan** if this surcharge will affect you and your family.
- **Who is NOT affected?** You will *NOT* be subject to the surcharge if:
  - Your spouse does not have access to medical coverage through their employer.
  - Your spouse is unemployed, self-employed without coverage, or retired.
  - Your spouse's employer does not offer medical insurance.



### Options for Your Family

- **Family Advantage Health Plan: THIS YEAR ONLY!** The City of Peoria is waiving the 12-month eligibility requirement during 2026 Open Enrollment.
- **If you are currently enrolled in the health plan** you can sign up for the FAHP during Open Enrollment.
- **After Open Enrollment, the 12-month eligibility requirement will apply again.**



### Medical Plan Updates

- **Medical:** Dental coverage will no longer be combined with your medical coverage with UMR.
- **Dental:** Still with UMR, but now a separate election.
- **Teladoc:** Behavioral Health and Dermatology are now available virtually!
- **Anti-obesity** weight loss medications will **no longer** be covered.

## How to Enroll:

### Learn more about your benefits!

Scan QR code or visit  
<https://www.cbmicrosite.com/cityofpeoria>



### Enroll online through Employee Self Service!

Scan QR code or visit  
<https://selfservice.peoriail.gov/ess>





# Contacts

## City of Peoria Benefits Contact

**HR Department - Benefits**      Phone – (309) 494-8586      Email – [rachel@peoriagov.org](mailto:rachel@peoriagov.org)

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	UMR	(800) 826-9781	<a href="http://www.umar.com">www.umar.com</a>
Dental Insurance	UMR	(800) 826-9781	<a href="http://www.umar.com">www.umar.com</a>
Vision Insurance	Superior	(800) 507-3800	<a href="http://www.superiorvision.com">www.superiorvision.com</a>
Flexible Spending Account	UMR	(800) 826-9781	<a href="http://www.umar.com">www.umar.com</a>
Health Savings Account	UMR through Optum Bank	(866) 234-8913	<a href="mailto:hsagroup@optumbank.com">hsagroup@optumbank.com</a>

# Eligibility

## 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.

- **Medical, Dental, Vision:** These coverages will take effect on the first of the month following 30 days of employment.
- **Other Coverages:**\* All other coverages will take effect on the first of the month following 30 days of employment.

**\* IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

## Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

### Definition of "Eligible Dependents"

**Medical, Dental, and Vision Coverage** dependents include:

- **Your legally married spouse or qualified Domestic Partner.** Such spouse/partner must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. Domestic Partners are required to complete an annual affidavit.
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- **Your dependent children age 26 or older who are mentally or physically disabled and total 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.
- **Any child who has been honorably discharged from military service up to age 30.** The dependent must be living in the state of Illinois. Additional premium may be charged for this coverage.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

## Open Enrollment Meetings

11/13/2025

7 am – 10 am

Public Works  
Main Conference Room  
3505 N Dries Lane

2 pm – 4 pm

Library North Branch  
McKenzie Room  
3001 W Grand Parkway

11/18/2025

9 am – 1 pm

City Hall  
Room 106B  
419 Fulton Street

2 pm – 4 pm

Library Main Branch  
1<sup>st</sup> Floor Meeting Room  
107 NE Monroe

11/19/2025

7 am – 9 am

2 pm – 5 pm

Fire Department  
Large Conference Room  
505 NE Monroe

11/21/2025

7 am – Noon

2 pm – 5 pm

*\*For Police, ECC & IS only*  
Police Department  
Command Post  
600 SW Adams

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 10 through November 20, 2025.** The benefits you choose during open enrollment will become effective Jan. 1, 2026.

### 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.

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

# Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck. Please contact Human Resources regarding any questions or concerns.

## City Employees and Elected Officials

UMR Low Deductible Plan			
Medical Only	Monthly	Semi-Monthly	Bi-Weekly
Member Only	\$102.52	\$51.26	\$47.32
Member + Partner	\$351.89	\$175.95	\$162.41
Member + Child(ren)	\$278.28	\$139.14	\$128.41
Member + Family	\$486.65	\$243.33	\$224.61

UMR High Deductible Plan			
Medical Only	Monthly	Semi-Monthly	Bi-Weekly
Member Only	\$48.77	\$24.39	\$22.51
Member + Partner	\$168.46	\$84.23	\$77.75
Member + Child(ren)	\$133.14	\$66.57	\$61.45
Member + Family	\$233.32	\$116.66	\$107.69

## Public Library Employees *(per pay amount)*

Medical Only	UMR Low-Deductible PPO Plan	UMR High-Deductible PPO Plan
Member Only	\$59.71	\$53.39
Member + Partner	\$123.33	\$110.05
Member + Child(ren)	\$106.10	\$94.72
Member + Family	\$170.64	\$152.29

## All Employees

Vision – monthly cost	
Member	\$6.19
Member + Partner	\$12.38
Member + Child(ren)	\$14.61
Member + Family	\$22.37

Dental – monthly cost	
Member	\$5.00
Member + Partner	\$15.00
Member + Child(ren)	\$12.00
Member + Family	\$20.00

# Medicare Education

Next Level Planning through our partnership with Cottingham & Butler

As people approach retirement, a common concern is the answer to the question:

**“What happens to my health insurance?”**

## Next Level Planning makes it easy!

- Get advice from licensed insurance agents at no cost or obligation to enroll.
- Explore plans from numerous health insurance companies.
- Learn more about Medicare and be guided through the process.
- Receive 1 on 1 assistance with benefit and financial planning.



**Connect with a Medicare consultant.**

(414) 369-6628 | [www.nlpwm.com](http://www.nlpwm.com)



**Want NLP to reach out?**

Scan QR code or visit:

<https://app.smartsheet.com/b/form/9f83ac0937fe480b8d110c7c09a77ed3>



## How else can Next Level Planning assist you?



Financial, Retirement & Estate Planning



Health Insurance



Business Planning & Executive Benefits



Insurance & Investments



Financial Education

# Maternity / Paternity Benefits

Benefits and Leave Information

## GROWING YOUR FAMILY?



Employees may be eligible for the following benefits:

- Car Seat Reimbursement
  - (up to \$125)
- Breast Pump Reimbursement
  - (up to \$200)
- FMLA Time off
- 2 Weeks Paid Time Off (City Employees Only)

**Contact Human Resources  
Benefits Admin:**

Rachel Cook  
309-494-8586  
rachel@peoriagov.org



# Medical

UMR – United Healthcare Choice Plus Network



Locate an in-network provider near you at [www.umar.com](http://www.umar.com) or call (800) 826-9781.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	Low Deductible PPO Plan		High Deductible PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Annual Deductible</b>				
Individual	\$1,500	\$4,000	\$4,500	\$10,000
Family	\$3,000	\$8,000	\$9,000	\$20,000
<b>Coinsurance</b> (Plan Pays/You Pay)	80% / 20%	50% / 50%	100% / 0%	100% / 0%
<b>Annual Out-of-Pocket Maximum</b>				
Individual	\$4,500	\$10,000	\$4,500	\$10,000
Family	\$9,000	\$10,000/person	\$9,000	\$20,000
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Preventive Care</b>	No Charge, Deductible Waived	Subject to Deductible	No Charge, Deductible Waived	
<b>Telemedicine</b>	\$25	\$25	Subject to Deductible	
<b>Primary Care Office Visit</b>	\$25 copay /visit; Deductible Waived	Subject to Deductible		
<b>Specialist Office Visit</b>	\$50 copay/visit; Deductible Waived			
<b>Urgent Care</b>	\$25 copay /visit; Deductible Waived	50% coinsurance		
<b>Emergency Room</b>	\$150 copay/visit; Deductible Waived			
<b>Hospitalization</b>	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance		

\*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.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

**Preventative Care at NO COST to you!**

Annual Wellness exam	Colonoscopy screening (age 50+)
Routine/Preventive labs	Routine annual PAP for women
Immunizations	Routine Annual PSA test for men
Preventative Mammograms	Annual Vision Screening

Must be billed as Wellness/Preventative, not Diagnostic

# 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](http://www.caremark.com) or call CVS/Caremark customer service at (866) 905-6237.

Prescription Drugs	UMR Low Deductible Plan CVS/Caremark Network	UMR High Deductible Plan CVS/Caremark Network (after medical deductible is met)
<b>Annual Out-of-Pocket Maximum</b> Individual / Family	\$2,900 / \$5,800	\$1,850 / \$3,700
<b>Tier 1 Generics</b>	\$5/month	
<b>Tier 2 Preferred Brands</b>	20% of discounted cost/month (\$50 max)	
<b>Tier 3 Non-Preferred Brands</b>	40% of discounted cost/month (\$100 max)	
<b>Tier 4 Specialty Drugs</b>	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](http://www.caremark.com). The 2026 Formulary will be updated on or after 1/1/26.

**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 CVS Specialty Pharmacy by calling 866-295-2779 from 6:30 a.m. – 8:00 p.m. Monday through Friday.

**Please review the full plan documents for details.** If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

# \$0 Copay Brand Name Prescriptions

CANARX

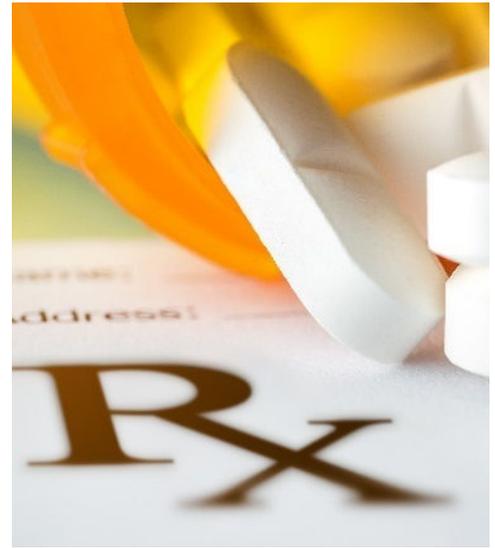
Available to those enrolled in the *City of Peoria medical plans*.

## Brand name medications FREE to your door!

Order brand name maintenance medications, in the original factory-sealed manufactures packaging directly to your door from certified pharmacies in Canada, the United Kingdom and Australia. **YOU PAY NOTHING (\$0 copay)** thanks to the savings this program brings to the medical plan!

## Getting started is easy!

1. **Check to see if your medication is offered.** Call or go online to view the complete formulary and enroll in the program.
2. **Ask your doctor for a prescription for a 3-month supply, with 3 refills** – so long as you have been taking the prescription for at least 30 days.
3. **Submit documentation** (completed enrollment form, prescription, and a copy of your photo ID).
4. **Sit back and relax.** Medication will be mailed direct to your home within 4 weeks!



Check to see if your brand name medication is offered!

**1-866-893-6337**



[www.canarx.com](http://www.canarx.com)

WebID: Peoria



# Family Advantage Health Plan (FAHP)

## ***THIS YEAR ONLY!***

- The City of Peoria is waiving the 12-month eligibility requirement during Open Enrollment.
- **If you are currently enrolled in the health plan** but have not been enrolled for the full 12 months, you can sign up for the FAHP during Open Enrollment.
- After Open Enrollment, the 12-month eligibility requirement will apply again.

## 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.

## Eligibility Criteria

To be eligible, the member<sup>1</sup> (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.<sup>2</sup>
2. Member has access to enroll in alternative employer-sponsored medical plan (e.g. via spouse, parent, 2nd job, etc.).

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

<sup>2</sup> 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;<sup>3</sup> or
2. Due to a qualifying event, such as spouse's open enrollment or change in status (e.g. marriage, birth of child, etc.).

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<sup>3</sup> **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](http://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](http://www.mywealthcareonline.com/bccsmartcare);
  - by
  - Email: [bcc-claims@benXcel.com](mailto: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:

- [customersupport@benXcel.com](mailto:customersupport@benXcel.com) | (412) 446 4651

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

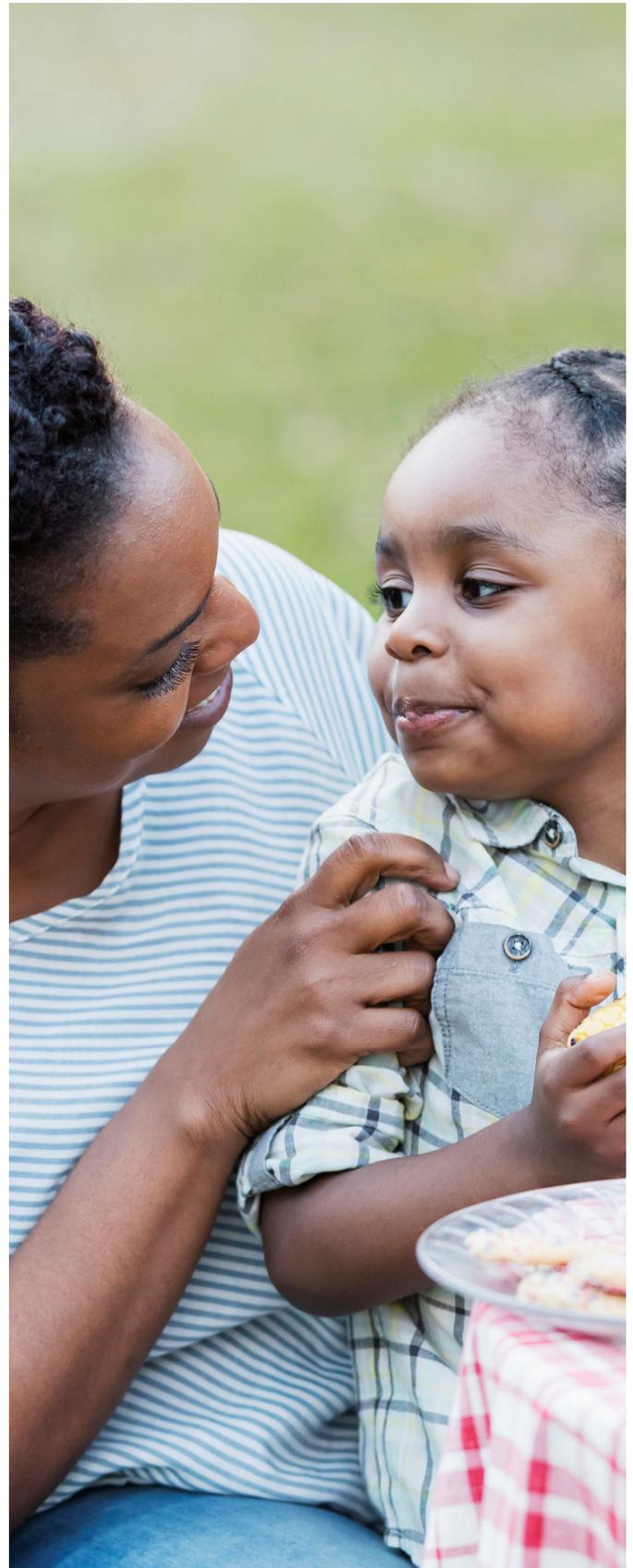
### Post-Enrollment

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:

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



# Flexible Spending Account

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 & Low Deductible Plans**.

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

## Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2026 annual contribution limit	\$3,400
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Rollover	\$680
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Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

## Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Before and after school programs
- Summer day camp
- Elder care

2026 annual contribution limit	Married (Filing separately)	\$3,750
	Single/Married (Filing jointly)	\$7,500



Is a Health FSA Right for You?

[www.cbmicrosite.com/video/healthfsa](http://www.cbmicrosite.com/video/healthfsa)



Visit [www.irs.gov](http://www.irs.gov) and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

**Even if you signed up for Health Care and/or Dependent Care FSA in 2025, you MUST re-enroll for 2026.**

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

# Health Savings Account

Optum Bank

Available to City and Library employees enrolled on the **High Deductible PPO** (not available to Township employees). If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.

**Is an HSA Right for You?**  
[www.cbmicrosite.com/video/hsa](http://www.cbmicrosite.com/video/hsa)

## HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

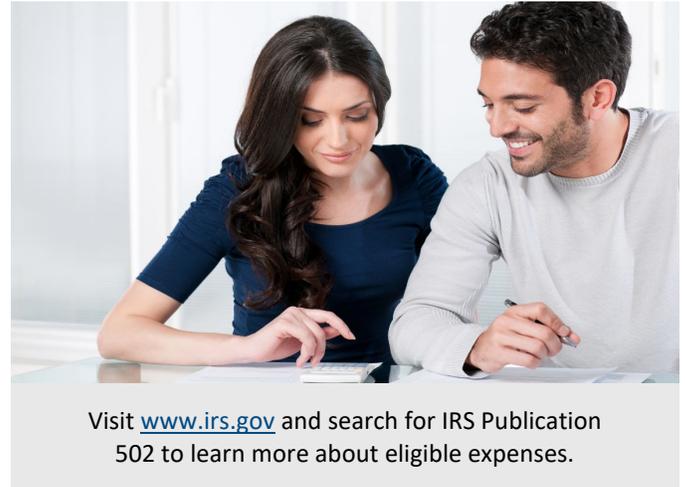
- Deductibles
- Coinsurance
- Other health-related expenses

2026 annual contribution limit	Individual	\$4,400	
	Family	\$8,750	
	Catch-up contribution (Age 55 or older)	\$1,000	
2026 annual max employee contributions*	Member Only	<b>City</b>	<b>Library</b>
		\$3,900	\$4,400
	Member + Partner + Children + Family	\$7,950	\$8,750
City Contribution	(prorated quarterly for new hires)	\$500	
Rollover		Full Amount	

\* This amount applies to the IRS annual contribution limit.

All HSA contributions require an open and active account. Contributions cannot be made and are forfeited if no active account exists and cannot be paid later or in a different form.

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.



Visit [www.irs.gov](http://www.irs.gov) and search for IRS Publication 502 to learn more about eligible expenses.

## HSA Case Study

Justin is a healthy 28-year-old single man who contributes \$1,000 each year to his HSA. His plan's annual deductible is \$1,600 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		Year 2	
<b>HSA Balance</b>	\$1,000	<b>HSA Balance</b>	\$1,850
<b>Total Expenses:</b>		<b>Total Expenses:</b>	
Prescription drugs: \$150		Office visit: \$100	
		Prescription drugs: \$200	
		Preventive care services: \$0 (covered by insurance)	
	- \$150		- \$300
<b>HSA Rollover to Year 2</b>	\$850	<b>HSA Rollover to Year 3</b>	\$1,550

Since Justin did not spend all his HSA dollars in year 1, the remaining funds roll over.

Once again Justin did not spend all his HSA dollars, so they roll over to the next year.

**Even if you signed up for a Health Savings Account in 2025, you MUST re-enroll for 2026.**

# Dental

UMR | No Network



Dental	Benefit
<b>Annual Deductible</b>	\$150 per individual \$300 per family
<b>Annual Benefit Maximum</b> (Includes Orthodontia Services, excludes Preventive Care Services)	\$2,000
<b>General Anesthesia / IV Sedation</b>	\$2,000
Plan Pays	Benefit
<b>Preventive Care</b> (Deductible waived) <ul style="list-style-type: none"> <li>• Oral exams, cleanings (2 per calendar year)</li> <li>• Fluoride Treatments (2 per calendar year, under age 18 only)</li> <li>• Sealants on teeth 1, 2, &amp; permanent molars (once every 36 months, under age 15 only)</li> <li>• Full Mouth X-Rays (once every 2 years)</li> <li>• Bitewing X-rays (4 per calendar year)</li> </ul>	100% Covered
<b>Basic Services</b> <ul style="list-style-type: none"> <li>• Appliances for Bruxism (grinding of teeth) – occlusal guards</li> <li>• TMJ Disorder (appliances for treatment of TMJ covered under Medical Plan)</li> <li>• Filling, Simple Extraction, Root Canal</li> <li>• Oral Surgery</li> <li>• Endodontic Procedures</li> <li>• Denture Repairs and Adjustments after first 6 months from obtaining dentures</li> </ul>	Subject to Deductible, then 20% coinsurance
<b>Major Services</b> <ul style="list-style-type: none"> <li>• Porcelain Crowns (except when in place of a tooth behind the 2nd bicuspid)</li> <li>• Porcelain Veneered Crowns</li> <li>• Bridges, Inlays, Onlays</li> <li>• Full and Partial Dentures</li> </ul>	Subject to Deductible, then 50% coinsurance
<b>Orthodontia Services</b>	Subject to Deductible, then 50% coinsurance

## Dental Monthly Cost

<b>Member</b>	\$5.00
<b>Member + Partner</b>	\$15.00
<b>Member + Child(ren)</b>	\$12.00
<b>Member + Family</b>	\$20.00

**PLEASE NOTE: You must have at least one preventive care visit yearly to maintain the full level of coverage.**

**Failure to do so will lessen your overall dental benefit coverage the following year.**

**\*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.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

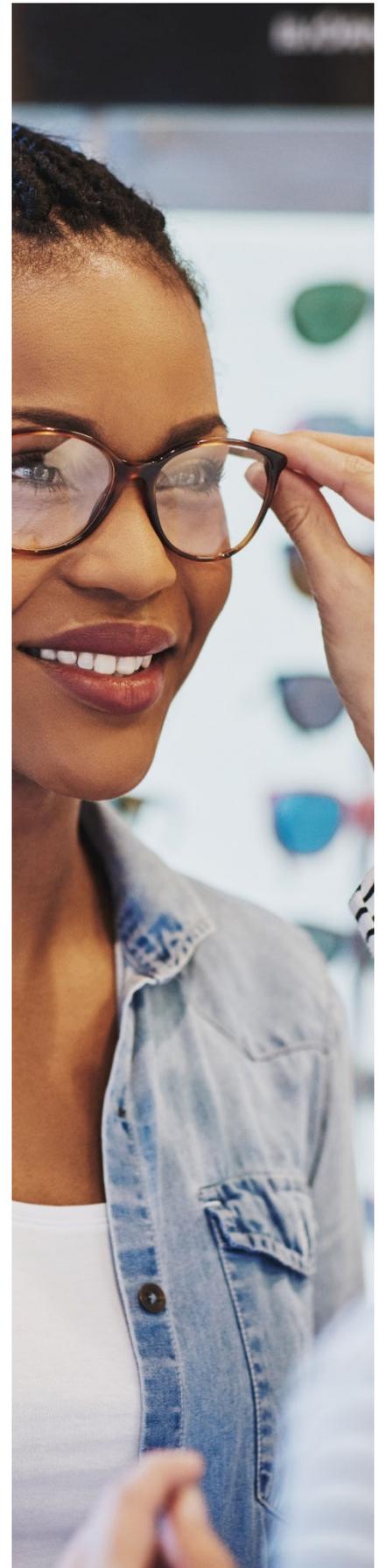
# Vision

Superior Vision | National Network

Vision		In-Network	
Exam		\$10 copay	
Lenses		Single vision Bifocal Trifocal Lenticular	\$25 copay
Frames (You pay the difference for frames above Max Benefit)		\$0 copay (\$150 max benefit)	
Contact Lenses – in lieu of lenses/frames (You pay the difference for lenses above Max Benefit)		Prescribed Contacts - \$0 copay (\$150 max benefit)	
		Fit & Follow Up - \$30 copay	
Frequencies – Based on Date of Service			
Exams		1 per 12 months	
Lenses or Contacts		1 per 12 months	
Frames		1 per 24 months	
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	
Vision Monthly Cost (First check of the month)			
Member		\$6.19	
Member + Partner		\$12.38	
Member + Child(ren)		\$14.61	
Member + Family		\$22.37	

Locate an in-network provider near you at [www.superiorvision.com](http://www.superiorvision.com) or call (800) 507-3800.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



# Healthcare Tips

## Get the Most Out of Your Care

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.

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 covered as out-of-network even though the primary physician is in-network.

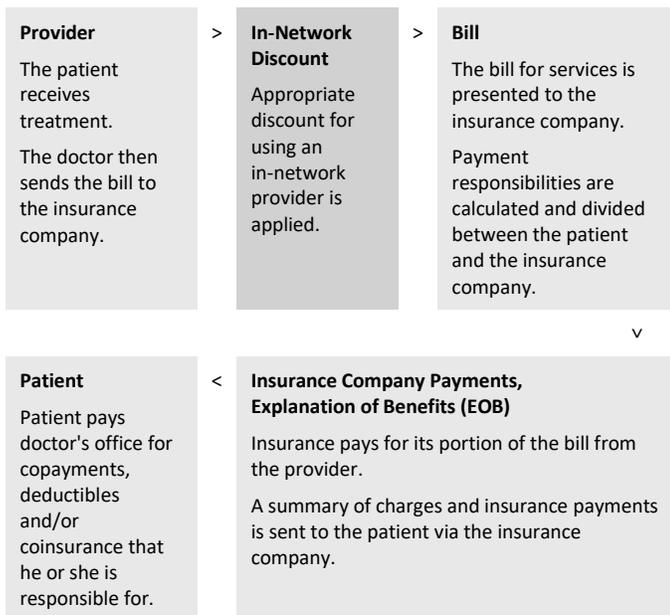


**Be a Smart Healthcare Shopper**

[cbmicrosite.com//video/smartshopper](http://cbmicrosite.com//video/smartshopper)

## Billing & Claim Differences

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



**Take advantage of 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, 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.



# Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs \$1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

## Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

### Emergency Room (\$\$\$\$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Uncontrollable bleeding
- Shortness of breath
- Poisoning



### Where Should I Go for Care?

[www.cbmicrosite.com/video/knowwheretogo](http://www.cbmicrosite.com/video/knowwheretogo)

### Urgent Care (\$\$\$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

### Doctor's Office (\$\$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

# 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.
- **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 and Welfare 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](http://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](http://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](http://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 March 17, 2025. V 0.5.0. 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](mailto: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](mailto: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://hcpf.colorado.gov/child-health-plan-plus>  
CHP+ Customer Service: 1-800-359-1991/State Relay 771  
Health Insurance Buy-In Program (HIBI) Website: <https://www.mycohibi.com/>  
HIBI Customer Service: 1-855-692-6442

### FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.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

Health Insurance Premium Payment Program  
All other Medicaid  
Website: <https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/>  
Family and Social Services Administration  
Phone: 1-800-403-0864  
Member Services Phone: 1-800-457-4584

### IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [iowa Medicaid | Health & Human Services](http://iowa.gov/Health&HumanServices)  
Medicaid Phone: 1-800-338-8366  
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://iowa.gov/Health&HumanServices)  
Hawki Phone: 1-800-257-8563  
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://iowa.gov/Health&HumanServices)  
HIPP Phone: 1-888-346-9562

### KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>  
Phone: 1-800-792-4884  
HIPP Phone: 1-800-967-4660

### 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: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@ky.gov)  
KCHIP Website: <https://kynect.ky.gov>  
Phone: 1-877-524-4718  
Kentucky Medicaid Website:  
<https://chfs.ky.gov/agencies/dms>

#### **LOUISIANA – Medicaid**

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

#### **MAINE – Medicaid**

Enrollment Website:  
[https://www.mymaineconnection.gov/benefits/s/?language=en\\_US](https://www.mymaineconnection.gov/benefits/s/?language=en_US)  
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: 711  
Email: [masspremassistance@accenture.com](mailto:masspremassistance@accenture.com)

#### **MINNESOTA – Medicaid**

Website:  
<https://mn.gov/dhs/health-care-coverage/>  
Phone: 1-800-657-3672

#### **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: [HSHIPPProgram@mt.gov](mailto:HSHIPPProgram@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://dhcfo.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. 15218  
Email: [DHHS.ThirdPartyLiabi@dhhs.nh.gov](mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov)

#### **NEW JERSEY – Medicaid and CHIP**

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>  
Phone: 1-800-356-1561  
CHIP Premium Assistance Phone: 609-631-2392  
CHIP Website:  
<http://www.njfamilycare.org/index.html>  
CHIP Phone: 1-800-701-0710 (TTY: 711)

#### **NEW YORK – Medicaid**

Website: [https://www.health.ny.gov/health\\_care/medicaid/](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: <https://www.hhs.nd.gov/healthcare>  
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 and CHIP**

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>  
Phone: 1-800-692-7462  
CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#)  
CHIP Phone: 1-800-986-KIDS (5437)

#### **RHODE ISLAND – Medicaid and CHIP**

Website: <http://www.eohhs.ri.gov/>  
Phone: 1-855-697-4347 or  
401-462-0311 (Direct Rlte 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: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>  
Phone: 1-800-440-0493

#### **UTAH – Medicaid and CHIP**

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>  
Email: [upp@utah.gov](mailto:upp@utah.gov)  
Phone: 1-888-222-2542  
Adult Expansion Website:  
<https://medicaid.utah.gov/expansion/>  
Utah Medicaid Buyout Program Website:  
<https://medicaid.utah.gov/buyout-program/>  
CHIP Website: <https://chip.utah.gov/>

#### **VERMONT – Medicaid**

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>  
Phone: 1-800-250-8427

#### **VIRGINIA – Medicaid and CHIP**

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>  
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>  
Medicaid/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 March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565 ❖

## Patient Protection Notice

If the City of Peoria Health and Welfare 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. 1<sup>st</sup>, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1<sup>st</sup>. After Dec. 15<sup>th</sup>, 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 9.02% 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](http://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 and Welfare 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](http://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](http://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: 10/03/2025

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 ❖

