The County of DuPage

2024
Benefit Guide

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About this Benefit Guide

This Benefit Guide contains a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. DuPage County reserves the right to amend, modify or terminate any plan at any time and in any manner.

A **Legal Notices** section is included at the end of this Benefit Guide to provide disclosure of the notices required by various federal laws such as the Patient Protection and Affordable Care Act, HIPAA, Women's Health and Cancer Rights Act, Medicare, etc.

If you have any questions about your benefits or the information in this guide, please contact Human Resources.

Important information about Medicare

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

IMPORTANT INFORMATION

Making Mid-Year Changes

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation. These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year [January 1 – December 31]. The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.
- Electing coverage under your state's Marketplace (also known as the Exchange) during annual enrollment or as a result of a special enrollment.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change. These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

Eligibility

Medical —You may cover your legal spouse (including a party to a civil union) and your eligible children through the end of the month in which they turn age **26**.

Disabled Dependent – If you have a disabled dependent who you intend to insure past the age of 26 you will need to complete a BCBSIL certification form along with the dependents physician. The dependent will need to have been covered prior to the disabling condition if it is not from birth. Be sure to submit this prior to the dependent turning age 26 to provide ample time for review and approval.

Dental and Vision—You may cover your legal spouse (including a party to a civil union) and your eligible *unmarried* children through the end of the month in which they turn age **26**. Tax dependents who are full-time college students can be covered on the dental and vision plans at no additional cost. **House Bill 5285**, an Illinois law, allows you to cover your *unmarried* children up to age **26,** at an additional charge**,** if they are not a full-time college student. Full-time college student status will be verified annually and your employee contribution may change based on this verification. If is your responsibility to notify Human Resources in the event of a change in this status mid-year. This bill also allows coverage up to age **30** if the child is an Illinois resident, served as a member of the active or reserve component of any branch of the Armed Forces of the US, and has received a release or discharge other than a dishonorable discharge. If you add a dependent under this legislation you will be charged monthly, per dependent, for the coverage.

Optional Life Insurance —You may cover your legal spouse (including a party to a civil union) and your eligible children age 15 days to age **26.**

MEDICAL PLANS

Choice of Plans

There are **four** medical plans to choose from, all through Blue Cross Blue Shield of Illinois (BCBSIL):

- Blue Advantage HMO
- Blue Choice PPO
- PPO 1
- BLUE EDGE Health Savings Account (HSA)

BlueCross BlueShield of Illinois

24/7 Nurse Line

BCBSIL provides you access to registered nurses to assist you with wellness and medical help at anytime. Call to determine what level of care may be needed for your medical concern.

Call 800-299-0274 for free

About the HMO Plan

- "HMO" stands for Health Maintenance Organization. The HMO plan from BCBSIL provides valuable benefits, member services and flexibility, along with the security of predictable copays so there are no financial surprises.
- Unlike the PPO plans, you are not required to pay a deductible.
- When you enroll in the Blue Advantage HMO from BCBSIL, you choose a contracting medical group within your network and then a family practitioner, internist or pediatrician from your chosen medical group to serve as your Primary Care Physician (PCP). Your PCP provides or coordinates your health care and makes referrals to specialists, when necessary.
- Female members also have the option of choosing a Woman's Principal Health Care Provider (WPHCP) to provide or coordinate their health care services. Your WPHCP and PCP must be affiliated with or employed by your Participating Medical Group.
- **The Blue Advantage HMO** contracting provider network is a subset of BCBSIL's larger HMO network. Although smaller, it offers a broad choice of contracting providers and is for members who are looking for a more affordable health care plan.
- To find a BCBSIL HMO provider, visit www.bcbsil.com or call Member Services. **You may also change your contracting medical group at any time simply by contacting Member Services.**

About the PPO Plans (Blue Choice PPO, PPO 1 and BLUE EDGE HSA)

- "PPO" stands for Preferred Provider Organization. Both BCBSIL PPO plans provide comprehensive coverage.
- You get the most benefits when you receive care from a contracting network provider. You don't need to choose a Primary Care Physician with a PPO, you can see any provider you want without a referral.
- Preventive care is covered at 100% and is not subject to the deductible.
- **Reference Based Pricing** applies to four treatment categories—CTs, MRIs, PETs, and Ultrasounds. Reference Based Pricing places a "cap" on the amount the plan will cover for certain medical services that have wide cost variations. The plan pays 100% up to the reference based price once the deductible is met. Member share (amount above reference based price) is applied to the out-of-pocket maximum.
- You can see a doctor outside the network, but your benefits will be reduced and you'll pay more out-of-pocket.
- To find a PPO provider, visit www.bcbsil.com or call Member Services. The PPO 1 and Blue Edge HSA plans utilize BCBSIL's national PPO network. The Blue Choice PPO utilizes a more limited network of providers through the Blue Choice PPO network.

About the Health Savings Account (HSA)

- The **BLUE EDGE HSA** is a consumer driven product that lets you decide how, when and where your health care dollars are spent. This plan gives you the option to combine a PPO plan with a tax-exempt Health Savings Account (HSA) to help cover the health care expenses you pay out of your own pocket, such as copays and deductibles. There is a lot of regulation around HSA contributions and distributions. If you are considering enrolling in this plan, you should consult your tax counsel to determine if your individual situation permits the use of an HSA.
- If enrolled in the BLUE EDGE HSA, you may establish an HSA in your name with the bank of your choice. Individuals may make HSA contributions through payroll deductions before state, federal and FICA taxes. You decide how much you want to put into the account to pay for health expenses not covered by the BLUE EDGE High Deductible Health Plan (HDHP).
- **The 2024 annual maximum contribution amounts for the HSA are $4,150 per individual or $8,300 per family. Individuals age 55 and older (and not enrolled in Medicare) may contribute an additional amount referred to as a catch-up contribution. The maximum annual catch-up contribution is $1,000.**
- Individuals decide when to withdraw money from their HSA for qualified health expenses (including expenses that count toward deductibles and coinsurance). BCBSIL will process the claim and determine your liability for the qualified medical expense, if any. If you owe any remaining dollars, the amount will be listed on your Explanation of Benefits (EOB) and you may use the debit card, checkbook, or your own personal funds to pay any balance due to the provider.
- You can choose to be reimbursed for medical expenses from your HSA **or** you can choose to pay for your medical care out-of-pocket until you reach your deductible—that is when the medical plan takes over. This approach allows the HSA funds to grow and earn interest for future qualified expenses.
- There is no "use it or lose it" rule with the HSA — balances can roll over year after year to provide for a "cushion" against future healthcare expenses.

Does the HSA "*earn interest*"?

- Yes! This is one of the best features of an HSA. Deposits are held in an interest-bearing checking account with the bank of your choice and the rates vary based on the balance in the account. The earnings accumulate tax free, and as long as the money in the account is used to pay for qualified health expenses, account holders will never pay taxes on the money deposited *or* the interest or earnings gained.

Can *everyone* participate in the HSA?

- No, not everyone. The Internal Revenue Code says that to participate in an HSA, individuals must be enrolled in an approved HDHP, they cannot be a dependent on another person's tax return, and cannot be covered by *another* plan if it's not an HDHP. So, individuals are not eligible for the HSA if covered by DuPage County's Health Care Flexible Spending Account or their spouse's Health Care Flexible Spending Account, covered as a dependent on their spouse's medical plan and that plan *isn't* a HDHP, *or* enrolled in Medicare.
- You can *still* enroll in the HSA if you have insurance for a specific disease (like the critical illness plan), or insurance that pays a fixed amount each day you're in the hospital. Coverage for dental, vision, long-term care, life and accidental death, and disability are okay too.

Are there any fees I have to pay to participate in the HSA?

- This would vary based on the bank you choose to work with.

What kind of health expenses can be paid for with HSA funds?

- Eligible or "qualified" expenses are defined by Section 213(d) of the IRS Tax Code. They are the same expenses that are eligible for reimbursement using your Health Care Flexible Spending Account.

About the Health Savings Account (HSA), cont.

Can I contribute to a HSA *and* be covered by my spouse's medical plan?

- Not if your spouse's plan is not a HDHP. But your spouse can be covered by both a HDHP and non-HDHP, and so can your children.

Can I use the money in my HSA to pay out-of-pocket health claims for my spouse or child?

- Yes, you can spend your HSA dollars on health expenses for yourself, or anyone you claim as a spouse or dependent on your personal income tax — even if that person isn't covered by your HDHP.

What if I start an HSA now, but lose eligibility later because I enroll in a *non*-HDHP?

- You need to be covered by a qualified HDHP to contribute to your HSA. So if you gain coverage under another plan that doesn't qualify as a HDHP, you'll need to stop making contributions to your HSA.

What about the money in my account?

- The money is still there for you to use for qualified health expenses. You can continue to withdraw the money in your account to pay for deductibles, copayments and other expenses. The money will continue to earn interest and grow over the years. Remember, there is no "use it or lose it" rules with HSAs. However, you must have the money in the account in order to request disbursements.

What happens after I turn age 65?

- You will not be able to contribute any more money to your HSA, but you will be able to continue to use the money in your account to pay for eligible medical expenses, as well as Medicare premiums and Medicare copays and coinsurance, and long term care insurance premiums.

Do I have to keep records about my HSA?

- Yes, you need to keep *complete records* so you can show the IRS that you've used the money in your account to pay for qualified healthcare expenses. You should keep a record of deposits and expenditures, and save all receipts. These records are subject to IRS audit, so keep everything in a safe place.

What if I use the money in my HSA to pay for something *other than* a qualified expense?

- You'll need to include that amount in your gross income when you file your taxes. It will be treated as regular income, and if you're less than age 65, it will be subject to a 20% tax penalty.

Working Spouse Surcharge

DuPage County will impose a **$150 per month surcharge** on employees that elect to cover working spouses who are eligible for group medical coverage through his/her own employer (other than through DuPage County), or spouses that are retired and have access to a health plan through his/her previous employer (other than through DuPage County). If, at any point, your spouse ceases to be eligible for his/her employer's medical coverage, he/she may be enrolled under your medical plan coverage. You will have 30 days from the loss of eligibility to enroll your spouse under our plan.

This surcharge does not apply toward dependent children. You are still able to enroll your dependent children in the County medical plan regardless of your spouse's status under this restriction.

If your spouse is covered under the DuPage County medical plan and it is later determined that your spouse was eligible for other group medical coverage through his/her own employer, you may be required to repay the cost of any claims incurred by your spouse from the date of ineligibility. You may also be subject to disciplinary action, including termination of employment and retroactive payroll contribution adjustments, for knowingly and willfully making a false or fraudulent statement or representation to DuPage County.

All eligible, married employees who enroll for spousal coverage on the DuPage County medical plan, must complete the Working Spouse Affidavit.

If you elect Employee + Spouse or Family coverage (with a spouse) and fail to return the Affidavit, your spouse will be removed from coverage. You may not make any changes to your election until the following annual benefit enrollment period unless you experience a qualifying event.

Tobacco User Surcharge

Our employee's health is very important to us. The impact that tobacco use has on our employees is substantial. Tobacco users are much more likely to develop serious chronic medical conditions, visit the doctor more often, or be absent from work with an illness—all of which are very costly for the County's health plan and productivity.

All employees enrolling in medical coverage must complete a Tobacco Status Affidavit.

- **If you smoke or use tobacco products on a regular basis** (within the last 6 months), a **$75 per month surcharge** will apply to your medical plan contribution.
- If you are a tobacco user and complete the **"Well On Target" Self-Directed Interactive Course titled "Quitting Tobacco Use", 6-week online smoking cessation program** available through BCBSIL (See *www.bcbsil.com* to login to your member account) by September 1, 2024, we will refund the tobacco user surcharge, and discontinue any further tobacco user surcharge for the remainder of the plan year.

PRESCRIPTION DRUG PLAN

Plan Information

Prescription drug coverage is included with your medical plan election. The amount you pay for each prescription depends on whether the prescription drug is a generic, formulary or non-formulary drug. The PPO utilizes a formulary called the Balanced Formulary. The Blue Advantage HMO utilizes a different formulary called the Performance Drug Formulary. The formulary lists are available for viewing at www.bcbsil.com.

PPO and HMO Plan Rx	Retail	Mail Order
Generic	$15	$30
Formulary Brand	$35	$70
Non-Formulary Brand	$55	$110

A separate out-of-pocket maximum applies to pharmacy coverage (all plans except Blue Edge HSA).

Prescription Drugs and the BLUE EDGE HSA:

Prescription drug costs go towards the deductible. Once the deductible is satisfied, prescriptions are covered at 100% after the applicable copay noted above.

Prior Authorization Program

This program applies to certain high-cost drugs that have the potential for misuse. Before medications included in the prior authorization program can be covered under your benefit plan, your doctor will need to get approval from BCBSIL. If you are prescribed a drug that is part of the prior authorization program, your doctor can submit a prior authorization request form so your prescription can be considered for coverage. Your doctor can find prior authorization forms at www.bcbsil.com. Doctors may also call (800) 285-9426 with questions, or to get a form.

Brand when Generic is available

When you fill a prescription through a contracting pharmacy for a covered brand name drug where a generic equivalent is available, you may pay more. You will pay the copay amount plus the difference in cost between the brand drug and its generic equivalent. Your pharmacist can often substitute a generic equivalent for its brand counterpart without a new prescription from your doctor. Only you and your doctor can decide if a generic alternative is right for you.

Step Therapy Program

Some medications will require a “step” approach to receive coverage for certain high-cost medications. This means that to receive coverage you may need to first try a proven, cost-effective medication before using a more costly treatment, if needed. If you start taking a medication that is included in the step therapy program, your doctor will need to write you a prescription for a first-line medication or submit a prior authorization request for the prescription before you can receive coverage for the drug.

PRESCRIPTION DRUG PLAN

Mail Order Prescription Drug Program (Blue Advantage HMO, and PPO2 HSA)

You can purchase a 90-day supply of most maintenance drugs for two copays through a network of contracting retail and mail service pharmacies. Visit www.bcbsil.com for the most up-to-date listing of contracting 90-day supply retail and mail service pharmacies.

Mail Order Prescription Drug Program (Blue Choice PPO, PPO 1)

You can purchase up to a 90-day supply of most maintenance drugs for two copays through the DuPage Convalescent County Services pharmacy. See the "Where To Go for Help" section of this guide for contact information.

Specialty Prescription Mail Order:

Specialty prescriptions are high cost medications that are used to treat complex chronic conditions. If you are taking a specialty medication you may need to fill this through the Accredo specialty pharmacy. The Accredo specialty pharmacy provides you with additional services that are often helpful to members who utilize specialty medications. Contact information is located in the "Where To Go for Help" section of this guide.

Pharmacy Network:

All PPO plans utilize the Advantage Pharmacy Network. This is a network of pharmacies that provides discounts on your prescriptions so you save money. This pharmacy network is large and includes Walgreens and many independent pharmacies. It is important to note that CVS pharmacies are not included in this network. You can locate the list of Advantage Network pharmacies by visiting www.bcbsil.com and log into your Blue Access for Members (BAM) account.

MEDICAL BENEFITS

	BLUE ADVANTAGE HMO
DEDUCTIBLES & DOLLAR MAXIMUMS	
Deductible Per Individual Family	 None None
Out-of-Pocket Maximum Per Individual Family	 $1,500 $3,000
	Includes coinsurance, and flat dollar copayments (excluding Rx)
HOSPITAL	
Room & Board	$250 copay per day of admission *(maximum $750 per plan year)*
EMERGENCY CARE	
Emergency Services *Covered services performed in a hospital emergency room in or out of area.*	$150 copay; copay waived if admitted
PHYSICIAN'S SERVICES	
Doctor's Office Visit	$25 copay (PCP) / $40 copay (Specialist)
Routine Physical Exam	100%
Diagnostic Tests and X-rays	100%
Immunizations	100%
Allergy Treatment & Testing	100%
Wellness Care	100%
MEDICAL SERVICES	
Outpatient Surgery Hospital Facility	 $125 copay
Infertility Office Visit	$40 copay
Mental Health & Chemical Dependency Treatment Outpatient Inpatient	 $25 copay $250 copay per day of admission *(maximum $750 per plan year)*
Outpatient Rehabilitation Services (includes, but not limited to, physical, occupational or speech)	$25 copay
	60 visits combined per calendar year
Outpatient Speech Therapy (for Pervasive Developmental Disorder only)	$25 copay
	unlimited
Durable Medical Equipment	100%
Ambulance Service	100%
Hospice	100%
Vision Care Exam only	$0 copay

MEDICAL BENEFITS

	PPO 1		BLUE CHOICE PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLES, COPAYS & DOLLAR MAXIMUMS				
Deductible Per Individual Family	$1,000 $3,000		$500 $1,500	
Coinsurance	80% most services	60% most services	80% most services	60% most services
Out-of-Pocket Maximum Per Individual Family	$3,500 $10,500	$10,000 $30,000	$3,000 $9,000	$9,000 $27,000
	Includes deductible, coinsurance, and flat dollar copayments (excluding Rx)		Includes deductible, coinsurance, and flat dollar copayments (excluding Rx)	
PHYSICIAN SERVICES				
Physician Office Visits	$30 copay (PCP) / $60 copay (Specialist)	60% after deductible	80% after deductible	60% after deductible
Urgent Care	$60 copay	60% after deductible	80% after deductible	60% after deductible
Preventive Health Care	100%	60%	100%	60%
Medical / Surgical Care and Mental Health / Substance Abuse	80% after deductible	60% after deductible	80% after deductible	60% after deductible
HOSPITAL SERVICES				
Inpatient Hospital Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery & Diagnostic Tests	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Emergency (Hospital & Physician)	$150 copay (waived if admitted)		80% after deductible	80% after deductible
ADDITIONAL SERVICES				
Muscle Manipulation Services	$30 copay	60% after deductible	80% after deductible	60% after deductible
	Up to 26 visits per year		Up to 26 visits per year	
Therapy Services—Speech, Occupational, Physical	80% after deductible	60% after deductible	80% after deductible	60% after deductible
	Speech—50 visits per calendar year Occupational—70 visits per calendar year Physical—115 visits per calendar year Speech Therapy for Pervasive Development Disorder only—no visit limit		Speech—50 visits per calendar year Occupational—70 visits per calendar year Physical—115 visits per calendar year Speech Therapy for Pervasive Development Disorder only—no visit limit	

BlueCross BlueShield of Illinois

MEDICAL BENEFITS

	BLUE EDGE HSA	
	In-Network	Out-of-Network
Deductible Per Individual Family	 $2,000 $4,000	 $4,000 $8,000
Coinsurance	90% most services	60% most services
Out-of-Pocket Maximum Per Individual Family	 $3,000 $6,000	 $6,000 $12,000
	Includes deductible, coinsurance, and flat dollar copayments (including Rx)	
PHYSICIAN SERVICES		
Preventive Health Care—Individuals age 26 and older	100%	60%
Preventive Health Care—Individuals up to age 26	100%	60%
Medical / Surgical Care and Mental Health / Substance Abuse	90% after deductible	60% after deductible
HOSPITAL SERVICES		
Inpatient Hospital Services	90% after deductible	60% after deductible
Outpatient Surgery & Diagnostic Tests	90% after deductible	60% after deductible
Outpatient Emergency (Hospital & Physician)	90% after deductible	90% after deductible
ADDITIONAL SERVICES		
Muscle Manipulation Services	90% after deductible	60% after deductible
	Up to 26 visits per year	
Therapy Services—Speech, Occupational, Physical	90% after deductible	60% after deductible
	Speech—50 visits per calendar year Occupational—70 visits per calendar year Physical—115 visits per calendar year Speech Therapy for Pervasive Development Disorder only—no visit limit	

MEDICAL BENEFITS

BCBSIL provides you with many valuable tools that you can utilize to manage your medical benefit plan. There is an online portal as well as a mobile app that provides you with access to your benefits 24/7.

Blue Access For Members (BAM)

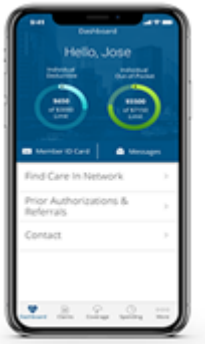
You can access this BCBSIL portal to learn about your plan coverage, order replacement ID cards, and view your claims. You can also find information on the cost and quality of care and also assistance with locating in-network physicians and facilities.

How to Register with BAM:

- Go to www.bcbsil.com
- Click on Create an Account
- Be prepared with the following information:
    - A valid email address
    - Your home zip code
    - Have your BCBSIL ID card as you will need your ID number and your group number

If you do not have your BCBSIL ID card available, you can call customer service for assistance.

BCBSIL offers a mobile app for your convenience. You can download the app by texting **BCBSILAPP to 33633** or locate it in Google Play or the Apple Store. You can manage your benefits on the go! Your ID card is within the app so you will never be without this important information. To choose to go paperless and/or receive text communications you can sign into the app and go to the Preferences page.



24/7 Nurse line

BCBSIL provides you with **FREE** advice anytime. Registered nurses are available to assist you with wellness and medical help at anytime. Call to determine what level of care may be needed for your medical concern. **Call 800-299-0274 for free assistance!**

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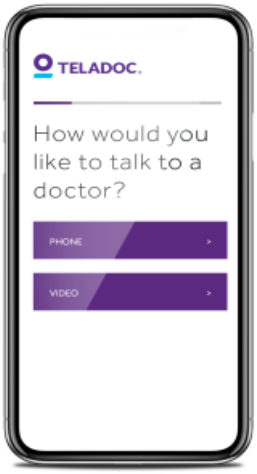


You've got Teladoc

Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to talk to a U.S.-licensed physician for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account

Use your phone, the app, or the website to create an account and complete your medical history

Talk to a doctor

Request a time and a Teladoc doctor will contact you

Feel better

The doctor will diagnose symptoms and send a prescription if necessary

Talk to a doctor for free

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

Teladoc is available to you and your dependents if you are enrolled in one of the following DuPage County medical plans: Blue Advantage HMO, PPO 1, or Blue Choice PPO. Teladoc is not available for those enrolled in the BlueEdge HSA or if you waive medical coverage.

HEALTHADVOCATE

Health Advocate is a free service offering a team of highly trained **Personal Health Advocates** who can work one-on-one with you to help resolve a wide range of healthcare and insurance- related issues that can be challenging for you and our Human Resources staff. Personal Health Advocates typically are registered nurses who are supported by a team of medical directors and benefits and claims specialists. Their primary function is to serve as your contact with healthcare providers, insurance companies and health-related community services. By doing all the work to resolve issues expertly and efficiently, the Personal Health Advocates ensure that you receive the information and support you need to remain fully productive at work, save money and optimize your healthcare experience.

How does the Health Advocate program work?

The Health Advocate program is available to you, your spouse and dependent children. When you call Health Advocate toll-free, you are assigned a Personal Health Advocate, who works with you to resolve your specific healthcare or benefits issues. Personal Health Advocates can help with a wide variety of concerns, ranging from deciphering claims and uncovering billing errors, to finding specialists and locating eldercare. You can work with the same Personal Health Advocate until the issue is completely resolved. Personal Health Advocates are also available to address any follow-up needs. The staff follows careful protocols and complies with government privacy standards. Your medical and personal information is strictly confidential.

Don't Know Where to Turn? Health Advocate will help:

- Find the right doctors, dentists, specialists and other providers
- Schedule appointments, arrange for special treatments and tests
- Locate the right treatment facilities, clinical trials
- Answer questions about test results, treatments and medications
- Research and locate newest treatments, secure second opinions
- Transfer medical records, x-rays and lab results

Confused by Health Insurance? Health Advocate cuts through the red tape by:

- Explaining coverage requirements, alternatives for non-covered services
- Getting appropriate approvals for covered services
- Addressing coverage for simple and complex treatments

Overwhelmed by Medical Bills? Health Advocate goes to bat for you to:

- Uncover mistakes
- Get estimates, negotiate fees, payment arrangements
- Supply providers with required information to pay a claim
- Get to the bottom of coverage denials
- Advise about appeals rights

Need Eldercare and Caregiver Services? Health Advocate eases your burden by:

- Finding in-home care, adult day care, assisted living, long-term care
- Clarifying Medicare, Medicaid and Medicare Supplemental plans
- Coordinating care among multiple providers
- Researching transportation to appointments
-

Once enrolled, you will receive the **Get Started Guide** which includes a set of wallet cards. You can reach Health Advocate toll-free at 1-866-695-8622 or by e-mail at *answers@HealthAdvocate.com*. Or visit their website at www.healthadvocate.com .

DENTAL COVERAGE

With Delta Dental, you can see the provider of your choice. The plan provides access to two of the nation's largest networks of participating dentists – **Delta's PPO network** and the **Delta Dental Premier network**. Delta Dental Premier dentists and Delta PPO dentists agree to accept Delta's fee as payment in full for covered services.

You may receive care from a *non-participating* dentist, but you'll pay more out-of-pocket because non-network providers can charge whatever amount they think is fair and balance bill you for the difference between the amount they charged Delta and the payment they actually receive from Delta.

To search for a dentist, visit www.deltadentalil.com.

DENTAL BENEFIT SUMMARY		
Item/Service	**Delta PPO**	**Premier or Non-participating**
Calendar Year Deductible (applies to Class II and III services)	$50 per member	$75 per member
Annual Benefit Maximum (all services except orthodontia)	$1,500 per member	$1,000 per member
Lifetime Orthodontic Maximum (children up to age 19, or 25 if full-time student)	$1,500 per member	$1,500 per member
CLASS I—DIAGNOSTIC AND PREVENTIVE SERVICES		
Oral Examinations—two per calendar year	100%	100%
Prophylaxis—two per calendar year		
Topical Fluoride Application—for individuals up to age 19; once per calendar year		
Routine X-rays—one full mouth every 3 years; two bitewing each calendar year		
Space Maintainers—for individuals up to age 16; once per lifetime		
Sealants—for individuals up to age 16		
CLASS II—BASIC RESTORATIVE SERVICES		
Fillings—amalgam and composite resin (including posterior teeth)	85%	75%
Extractions		
Oral Surgery		
Endodontics		
Periodontics		
CLASS III—MAJOR RESTORATIVE		
Bridge Repairs	55%	45%
Cast Restorations—crowns, onlays, post and core		
Prosthodontics—bridges, partial dentures and complete dentures		
Repair, reline, rebase and adjustments to dentures		
Implants		
CLASS IV—ORTHODONTICS		
Lifetime Deductible	$50	$75
Orthodontia	50%	50%

VISION COVERAGE

Our vision plan is insured by Superior Vision Services. Our vision plan offers in- and out-of-network benefits. You can seek services from the vision provider of your choice; however, you will receive richer benefits and have lower out-of-pocket costs when you visit a Superior Vision provider

Superior Vision has a nationwide network of more than 48,500 providers. Retail locations include Lens Crafters, Pearle Vision, Costco, Target, Sears, JC Penney, Wal-Mart and many more. The network provider panel includes:

- Optometrists (ODs)
- Ophthalmologists (MDs)
- Opticians

If you seek services out-of-network, you may need to pay the provider directly and file a claim for reimbursement with Superior Vision.

For more information on the vision benefit, you can contact Superior Vision or search for a provider on their website at www.superiorvision.com. You will select "Superior National" from the network drop-down box.

VISION BENEFIT SUMMARY		
Service	**In-Network Benefit**	**Out-of-Network Reimbursement**
Eye Exams—every 12 months	100% after $10 copay	Up to $37 retail allowance (Ophthalmologist) Up to $28 retail allowance (Optometrist)
Frames—every 24 months	Up to $125 retail allowance	Up to $58 retail allowance
Contact Lens Fitting (standard)	Covered in full	Not covered
Contact Lenses (in lieu of lenses and frames)—every 12 months	Up to $100 retail allowance	Up to $80 retail allowance
LENSES—every 12 months		
Single Lenses	100% after $15 copay	Up to $28 retail allowance
Bifocal		Up to $40 retail allowance
Trifocal		Up to $53 retail allowance

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) let you pay for health care and day care expenses with tax-free dollars. They help you stretch your money and reduce your federal, state, and social security taxes. How much you save depends on how much you pay in income tax.

There are two types of accounts under this plan: a Health Care Flexible Spending Account and a Dependent Care Flexible Spending Account. Enroll in one account or both. WEX / Discovery Benefits administers the plan for us.

With a Health Care FSA or a Dependent Care FSA, you decide before the start of the year how much to contribute to each account. Your contributions are withheld in equal amounts from your paychecks throughout the year. The money goes into an account(s) set up in your name. Claim the money in your account(s) by using your debit card or by filing a claim form for reimbursement.

There is a 2 ½ month grace period at the end of the plan year in which you have to incur any additional expenses. Under this provision, participants who have funds remaining in their accounts at the end of the plan year (December 31, 2024) can use those funds to pay expenses they incur during the next two and a half months (in other words, through March 15, 2025).

Participants have until March 30, 2025 to submit claims incurred in 2024 (and the 2 1/2 month grace period), for reimbursement.

How the Accounts Save You Money	Without a HCRA or DCRA	With a HCRA or DCRA
Gross Salary	$25,000	$25,000
Less Annual Amount Deposited into HCRA / DCRA	$0	($2,000)
Taxable Income	$25,000	$23,000
Less Annual Taxes (assumed at 25%)	($6,250)	($5,750)
Net Salary	$18,750	$17,250
Less Out-of-Pocket Medical and/or Dependent Care Expenses for the Year	($2,000)	N/A
Disposable Income	$16,750	$17,250
Tax Savings	None	$500

Health Care FSA

- The Health Care FSA helps you pay for medical, dental, and vision expenses that aren't covered by insurance. **You can contribute up to $3,050 into the HCRA in 2024**. The full amount will be available January 1, 2024.
- For a complete list of the expenses eligible for reimbursement, visit the IRS website at https://www.irs.gov/pub/irs-pdf/p502.pdf.
- You can also use tax-free dollars in your HCRA to pay for some over-the-counter (OTC) supplies (band-aids, first aid kits, reading glasses, contact solution) that you need for medical reasons. Over-the-counter drugs and medicines are only eligible with a doctor's prescription.
- To file a claim for OTC supplies, get an itemized receipt that show the supplies you bought, the date you bought it, and how much it cost.

FLEXIBLE SPENDING ACCOUNTS, CONT.

Dependent Care FSA

- This account lets you pay eligible dependent care expenses with pre-tax dollars. Most child and elder care and companion services are eligible expenses too. Your dependents must be:
    - Under age 13 or mentally or physically unable to care for themselves
    - Spending at least 8 hours a day in your home
    - Eligible to be claimed as a dependent on your federal income tax
    - Receiving care when you are at work and your spouse (if you are married) is at work or is searching for work, is in school full-time, or is mentally or physically disabled and unable to provide the care
- **In 2024, you can contribute up to $5,000 into the Dependent Care FSA**. But if both you and your spouse work, the IRS limits your maximum contribution.
    - If you file separate income tax returns, the annual contribution amount is limited to $2,500 each for you and your spouse
    - If you file a joint tax return and your spouse also contributes to a Dependent Care FSA, your family's combined limit is $5,000
    - If your spouse is disabled or a full-time student, special limits apply
    - If you or your spouse earn less than $5,000, the maximum is limited to earnings under $5,000
- With a Dependent Care FSA, you can be reimbursed up to the amount that you have in your account. If you file a claim for more than your balance, you'll be reimbursed as new deposits are made.
- Eligible dependent care expenses can either be reimbursed through the Dependent Care FSA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually the Dependent Care FSA will save more money than the tax credit. But to find out what is best for you and your family, talk to your tax advisor or take a look at IRS publication 503 at http://www.irs.gov/publications/p503/index.html.
- If you contribute to a Dependent Care FSA, you must file an IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

Use It or Lose It

The IRS says that money left in a Flexible Spending Account at the end of the year (and applicable grace period) has to be forfeited. People call this the "use it or lose it" rule. You can avoid losing money with some planning.

Many out-of-pocket costs are predictable. If you pay $55 every month for a brand name drug, set aside $660 ($55 x 12 months) and pay the copays with tax free money.

Remember that your tax savings are a "cushion". You must leave a balance of more than your tax savings to "lose". Let's say you deposit $1,000 in an account—you will save about $250 in taxes (with a 25% tax rate). ***Even if you forfeit $250, you will still break even!***

LIFE / AD&D INSURANCE

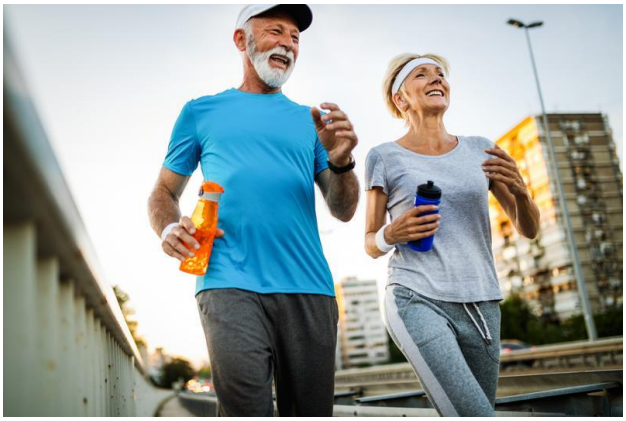
Basic Life / AD&D Insurance

Life insurance is extremely important if you have family members that depend on your income. Life insurance provides financial security for you or your dependents should you die while an employee of DuPage County. Accidental Death and Dismemberment (AD&D) insurance pays an *additional* benefit, equal to your Basic Life amount, if your death is a result of an accident.

DuPage County provides a company paid Basic Life/AD&D benefit to you, and then provides you with the opportunity to purchase additional life coverage for yourself and your eligible dependents.

All eligible employees are insured for a Basic Life/AD&D benefit equal to $25,000.

Your Basic Life/AD&D benefits reduce by 50% at age 70. Coverage effective dates and increases in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate/benefit booklet for details.



Optional Life Insurance

Many employees want more life insurance than the County-provided Basic Life Coverage. As a result, we provide an Optional Life Insurance plan, insured by The Hartford. You have the option to purchase additional coverage for yourself, your spouse, and your dependent children.

Individual	Optional Life Benefit	Do You Need To Provide Evidence of Insurability (EOI)?
Employee	$10,000 increments, to a maximum of $300,000	Yes, for amounts over $100,000 when first eligible. EOI is also required for any coverage amount, if you are enrolling for coverage more than 31 days after you were first eligible or if you are increasing your current coverage amount.
Spouse	$10,000 increments, to a maximum of $300,000; not to exceed employee amount	Yes, for amounts over $30,000 when first eligible. EOI is also required for any coverage amount, if you are enrolling for coverage more than 31 days after you were first eligible or if you are increasing your current coverage amount.
Child(ren)	For children age 15 days to age 26 $5,000 for each child	No

NOTE: Increased coverage does not become effective until your request has been approved by The Hartford. You must have coverage on yourself in order to cover your eligible dependents. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect as you must be actively at work to elect coverage. Review the carrier certificate/booklet for details.

VOLUNTARY BENEFITS

Voluntary Critical Illness

While you don't plan to become critically ill, you can make sure you're prepared financially. If you're ever diagnosed with a major illness such as cancer, a heart attack or a stroke, critical illness insurance can help you focus on recuperation instead of medical and personal bills.

The Hartford pays cash benefits directly to you and you can choose how to use the this added financial resource. The Critical Illness insurance plan will provide you with cash benefits for the following health events:

- Cancer
- Heart attack or stroke
- Major organ transplant
- End-stage renal failure
- Severe burns
- Multiple sclerosis

For the cost of a coffee, you can protect your family. If you are 35, you can purchase $20,000 of coverage for $9 a month!

Employees can elect up to $30,000 in coverage. The spouse benefit can be up to 50% of the employee benefit. Children automatically receive a benefit equal to 25% of the employee election. Premium rates are based on the employee age for both employee and spouse. You will find all the premium rates on the application.

Voluntary Accident Insurance

Accidents happen. Luckily you can choose coverage to make sure you're protected. After an accident, you may have expenses you've never thought about. Accident insurance from helps with out-of-pocket costs that arise when you have a covered accident such as a fracture, dislocation, or laceration.

This plan pays cash benefits directly to you and you can choose what you want to use the funds for. The following are some accident events that are payable benefits:

- Emergency Room Visit - $200
- Hospital Admission - $1,500
- Urgent Care - $150
- Ground Ambulance - $750
- X-ray - $150
- Concussion - $350

Monthly Accident Premium Rates			
Employee	Employee & Spouse	Employee & Child(ren)	Family
$6.36	$10.13	$10.76	$16.92

HOW TO ENROLL!

During open enrollment, visit the following website to review the plan details and enroll:

www.TheHartford.com/benefits/enroll

User ID: This is your DuPage County employee ID (locate this on your paystub)

Password: This is your initials and date of birth (i.e. JL03071969)

If you want to enroll outside of open enrollment (i.e. New Hire) you will need to obtain a paper enrollment form from Human Resources.

Important Note: You must be actively at work to purchase coverage. All elections are guarantee issue so no medical questions are required. Pre-existing limitations may apply. Coverage is portable so you can take this plan with you if you leave employment with DuPage County. The plans have limitations and exclusions that apply.

VOLUNTARY BENEFITS

LegalShield / IDShield

Effective January 1, 2024, the LegalShield and IDShield plans will be enhanced with new and improved benefits and will also include an increase in pricing. The new plans are available to all eligible employees.

LegalShield | Top LegalShield Benefits

Access to a Provider Law Firm for legal advice and consultation on any personal legal matter, even pre-existing ones.

Estate Planning Preparation — Will, Medical Directives, Financial and/or Healthcare Power of Attorney.

Moving Traffic Ticket Assistance with non-criminal, moving traffic matters when driving with a license and proper registration.

Document Review — Your provider law firm reviews personal documents (up to 15 pages each).

Letters And Phone Calls made on your behalf to help resolve consumer legal disputes.

Uncontested Family Law — Divorce, separation, adoption and/or name change.

Discounted Legal Services — For legal matters that are not covered at 100%, get a 25% discount on the provider law firm's standard rate.

IDShield | Top IDShield Benefits

360 Degree Protection — Threat monitoring of your identity, credit, financial accounts, device, online reputation and social media.

Real-time Alerts — Receive an alert on your mobile app, member portal and email when a threat is detected to your identity or credit.

Financial Protection — $3 Million Identity Fraud Protection for unauthorized electronic fund transfers and identity theft-related expenses.

Full-Service Restoration — In case of theft, you get a licensed private investigator to restore your identity to its pre-theft status.

Unlimited Consultation gives you access to an identity theft specialist for consultation on any identity theft or online privacy concern.

Trend Micro/Malware Protection & VPN — Maximum malware protection for your PCs and mobile devices. Complete Wi-Fi security when using public hotspots to prevent hacking attacks.

	All Employees	
Plan	**Individual**	**Family**
LegalShield	$20.95	$20.95
IDShield	$22.95	$12.95
LegalShield and IDShield	$40.95	$33.90

To enroll in coverage, visit:
www.legalshield.com/info/dupageco

If you purchase a plan, you gain access to MEMBERPERKS. This program provides you with discounts from hundreds of merchants! Members can access savings at both national and local companies on everyday purchases such as tickets, electronics, apparel, travel and more. To get started, sign up at https://legalshield.perkspot.com. Follow the simple on-screen instructions to create an account with your email and LegalShield Membership number.

LegalShield | MEMBERPerks

VOLUNTARY BENEFITS

Employee Assistance Program (EAP)

DuPage County provides an Employee Assistance Program (EAP) through Workplace Solutions. This program gives you and anyone in your household, access to no-cost consultations for assistance with resources and referrals related to work, family, health and everyday living. Participation is confidential and voluntary. Topics include:

Child care & parenting	*Daily living*	*Adoption*	*Financial*
Older adult care	*Education*	*Legal*	*ID Recovery*

Counselors are available 24/7 to speak with you confidentially at (877) 215-6614. You can also visit their website at www.wseap.com to find information and resources based on your needs and interests.

457 Deferred Compensation Plan

Financial experts estimate that you will need at least 75 to 85 percent of your pre-retirement income to maintain your lifestyle during retirement. A deferred compensation savings plan, along with other retirement funds, Social Security and, perhaps an employer pension, plays an important role in meeting your retirement goals. Deferred compensation is a program that allows you to invest today for your retirement. The County offers ICMA-RC as the deferred compensation provider.

LEGAL NOTICES

Qualified Changes in Status / Changing Your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1 – December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.
- Electing coverage under your state's Marketplace (also known as the Exchange) during annual enrollment or as a result of a special enrollment.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources. The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or

- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this packet.

LEGAL NOTICES

Important Notice from DuPage County About Your Prescription Drug Coverage and Medicare

Notice of **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 DuPage County 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. **DuPage County has determined that the prescription drug coverage offered by Blue Cross/Blue Shield 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 through 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 DuPage County coverage will not be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current DuPage County coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 DuPage County 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.

LEGAL NOTICES

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 **DuPage County** 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(TTY1-800-325-0778).

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:	October 2023
Name of Entity/Sender:	DuPage County
Contact Office:	Human Resources
Address:	421 N. County Farm Rd., Wheaton, IL 60187
Phone Number:	630-407-6300

LEGAL NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program
Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

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

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

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

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
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+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
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
HIPP Phone: 1-800-867-4660

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: 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/agencies/dms

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.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

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: 1-573-751-2005

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: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: https://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: 1-603-271-5218
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: 1-609-631-2392
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: 1-919-855-4100

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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
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 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
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 July 31, 2023, or for more information on special enrollment rights, contact either:

· U.S. Dept. of Labor, Employee Benefits Security Administration:
http://www.dol.gov/agencies/ebsa
Phone: 1-866-444-EBSA (3272)

· U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services: http://www.cms.hhs.gov/
Phone: 1-877-267-2323, Menu Option 4, Extension 61565

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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

Women's Health and Cancer Rights Act of 1998
The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our health plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and co-insurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a postsecondary education loses full-time student status due to a severe illness or injury, he/she will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

House Bill 5285:

Effective January 1, 2010, DuPage County must abide by the provisions of Public Act 95-0958, a new Illinois law that gives parents with insurance policies that cover dependents the right to elect coverage for qualifying unmarried dependents up to age 26 and up to age 30 for unmarried military veteran dependents. If you add a dependent under this new legislation, you will be separately charged (pre-tax) for the cost of the dependent's coverage. **This applies to dental and vision coverage only.**

LEGAL NOTICES, CONT.

County of DuPage
Notice of Privacy Practices
Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60-days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (630) 682-7344.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record that is related to your treatment. This information is necessary to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

Payment: We may use or disclose your health information in order to process claims or make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim to us for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

Home Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided to our organization through contracts with third party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Communication with Family or Friends: Our service professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

County of DuPage
Notice of Privacy Practices
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Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fund Raising: We may contact you as part of a fund-raising effort.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, we may disclose health information about you as required by military command.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Protective Services for the President, National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement: We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.

Inmates: We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.

Lawsuits and Disputes: We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Plan Sponsors: We may disclose health information about you to your plan sponsor to carry out plan administration functions that the plan sponsor performs upon certification by the plan sponsor that the plan documents have been amended as set forth under HIPAA regulations.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer.

Right to Request Restrictions: You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction.

Right to Receive Confidential Communications: You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy: You have the right to inspect and copy health information that we maintain about you in a designated record set. A "designated record set" is a group of records that we maintain such as enrollment, payment, and claims adjudication record systems. If copies are requested or you agree to a summary of explanation of such information, we may charge a reasonable, cost-based fee for the costs of

LEGAL NOTICES, CONT.

copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend: You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason for an amendment. We may deny your request if we determine that the record that is the subject of the request was not created by us, is not available for inspection as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12 -month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period.

Right to Obtain a Paper Copy: You have the right to obtain a paper copy of this Notice of Privacy Practice at any time.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

If you believe that your privacy rights have been violated, please submit your compliant in writing to:

County of DuPage
Human Resource Department
Attn: Privacy Officer
421 N. County Farm Rd.
Wheaton, IL 60187

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

WHERE TO GO FOR HELP

Provider	Benefit	Contact Information	
BCBSIL	Medical HMO	General info / finding a provider	(800) 892-2803 http://www.bcbsil.com
		Pharmacy questions	(800) 423-1973
		PrimeMail by Walgreens Mail	(888) 211-9028
		Service	www.walgreens.com/PrimeMail
BCBSIL	Medical PPO	General info / finding a provider	(800) 327-8497 www.bcbsil.com
		Pharmacy questions	(800) 423-1973
		DuPage Care Center	(630) 784-4288
		Services pharmacy mail	
		Choice PPO, PPO 1)	
		Accredo Specialty Pharmacy	(833) 721-1619
			https://www.accredo.com/bcbsil
		PrimeMail by Walgreens Mail	(888) 211-90285
		Service (BLUE EDGE HSA)	www.walgreens.com/PrimeMail
Delta Dental of IL	Dental	General info / finding a provider	(800) 323-1743 www.deltadentalil.com
Teladoc	Telemedicine	Request a consult	(800) 835-2362 www.teladoc.com
Superior Vision Services (SVS)	Vision	General info / finding a provider	(800) 507-3800 www.superiorvision.com
WEX / Discovery	Flexible Spending	Claims / general questions	(866) 451-3399
Benefits	Accounts		(866) 451-3245 (fax)
			customerservice@discoverybenefits.com
			https://www.wexinc.com/
The Hartford	Basic Life / AD&D Insurance Optional Life Insurance	Claim and service questions	(800) 523-2233 www.thehartford.com
The Hartford	Voluntary Critical Illness and Accident Insurance	All inquiries	(800) 523-2233 www.hartford.com
Health Advocate	Health Advocacy	All inquiries	(866) 695-8622 answers@HealthAdvocate.com https://www.healthadvocate.com/site/
Workplace Solutions	Employee Assistance Program	All inquiries	(877) 215-6614 www.wseap.com
Legal Shield	Legal Services	All inquiries	Jen Carpenter (815) 546-1897 Jencpta55@gmail.com To enroll: https://shieldbenefits.com/dupageco/overview
457 Deferred Compensation	Retirement Savings	Mission Square	Kim Brownlee (800) 291-9483
			kbrownlee@missionsq.org
IMRF	Pension Benefits	All inquiries	(800) 275-4673 www.imrf.org

Benefit Guide