



Tazewell County Employee Benefits

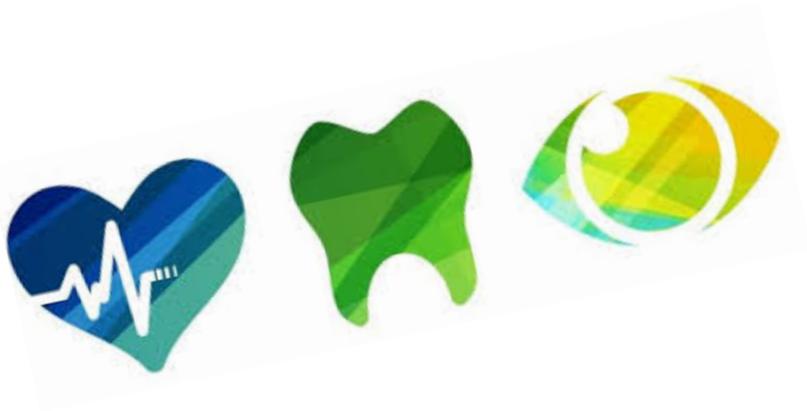


Table of Contents

	Page
Paid Leave	
• Holidays	3
• Vacation	4
• Sick Days	5
• Bereavement Leave	6
• Paid Time Off (PTO) Under PLFAWA	6
• Family Bereavement Leave	6
• Blood Donation Leave	7
• Illinois Voting Law	7
Health Plan	
• 2026 Plan Summary	8
• Traditional PPO Plan	9-13
• Mid-Level PPO Plan	14-18
• HDHP PPO Plan	19-23
• Dental Plan	24-27
• VSP Vision Plan	28-29
• OPYN Health Virtual Urgent Care	30
• Flexible Spending Account	31
• Health Saving Account	31
• CancerCare	32
Retirement	
• IMRF	33
• IMRF SLEP	34
• 457(b) Deferred Compensation	35
Employee Assistance Program	36
Voluntary Benefits	
• IMRF NCPERS	37
• AFLAC	37
• CIGNA AD&D	37
• Legal Shield	37
Employee Health Club Discount	38
Direct Deposit	39
Symetra Life Insurance	39
Wellness Offers to Employees	39
Professional Development	40



PAID LEAVE

Holidays

The County pays full-time employees and permanent part-time employees who work at least 24 hours per week for eleven (11) holidays each year. The annual holiday schedule for Tazewell County will be as follows: New Year's Day, Presidents Day, Good Friday, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving, Day After Thanksgiving, Christmas Eve and Christmas Day

When a holiday falls on a Saturday, the previous Friday shall be given as a holiday, except Christmas Day in which case it will be the following Monday. When a holiday falls on a Sunday, the following Monday shall be given as a holiday, except Christmas Eve Day, in which case it will be preceding Friday.

Permanent part-time employees who work at least 24 hours per week are eligible to receive holiday pay in an amount equal to their regularly scheduled shift and only when a regularly scheduled holiday falls on their regularly scheduled workday. Temporary part-time employees are not eligible for holiday pay and permanent part-time employees who work less than 24 hours per week are not eligible for holiday pay.

The employees will be paid for holidays only if they work the entire day before and the entire day after a holiday, unless they have an excused absence. A holiday falling during an employee's regularly scheduled vacation period shall be counted as a holiday and not as a vacation day.

Holiday pay will be forfeited if an employee calls in sick without 24 hour notice or approval of their immediate supervisor before or after a recognized holiday unless otherwise required by law.

Exempt employees receive the same salary they would have received for the week had the holiday not occurred. All non-exempt employees who must work on a designated holiday, or on the day the holiday is recognized, will receive time and half their normal rate of pay for any holiday hours worked, in addition to their holiday pay. All non-exempt employees required to take off on the day a holiday is recognized, and for which they would otherwise normally be scheduled to work, will receive regular pay (base pay) for the holiday.



Vacation

All full-time employees are eligible to take paid vacation two (2) months after their date of hire. Vacation shall be accrued and earned according to the following schedule:

Ten (10) working days after completion of one (1) year of service. Vacation is accrued at the rate of 2.885 hours per pay period for employees working a 37.5 hour week and 3.09 hours per pay period for employees working a 40 hour week

Fifteen (15) working days after five (5) years of service. Beginning the first day of the fifth year of service, vacation is accrued at the rate of 4.327 hours per pay period of employees working a 37.5 hour week and 4.620 hours per pay period for employees working a 40 hour week.

Twenty (20) working days after ten (10) years of service. Beginning the first day of their tenth year of service, vacation is accrued at the rate of 5.769 hours per pay period for employees working a 37.5 hour week and 6.154 hours per pay period for employees working a 40 hour week.

Twenty-five (25) working days after eighteen (18) years of service. Beginning the first day of their eighteenth year of service, vacation is accrued at the rate of 7.212 hours per pay period for employees working a 37.5 hour week and 7.692 hours per pay period for employees working a 40 hour week.

Managers have the ability to negotiate the amount of vacation provided to a new employee in certain positions up to the 15 day accrual category. Appointed officials should discuss this option with County Administration.

Vacation accruals apply only to regular hours worked and not to overtime hours.

Vacations may be scheduled (after eligibility requirements are met) with the approval of the Elected Official or Appointed Department Head. It is also essential that vacations be scheduled as far in advance as possible so that the normal work routine will not be disrupted.

The maximum amount of vacation an employee may carry over from one calendar year (January 1st to December 31st) to the next calendar year is 120 hours. Employees who have unused accrued vacation hours in excess of the maximum carry over amount, may cash in up to one (1) week of accrued vacation. Unused vacation above these limits will be lost without compensation.

If an employee resigns, a lump sum payment of all accrued unused vacation time will be included in the final paycheck.



Sick Days

Beginning upon full-time employment, sick leave will be accumulated to twelve (12) days per year. Accruals will be credited on the 1st and 2nd pay period of each month in an amount of 3.75 hours for 37.5 hour employees and 4.00 hours for 40.00 hour employees. Sick days may be accumulated to a maximum of two hundred and forty (240) days. Part-time and temporary employees are not eligible for sick days. Employees covered under collective bargaining agreements should refer to the respective contract or written agreement language.

Sick leave is defined as time accrued and available to an employee to be used for absences due to personal illness, injury or medical appointment; or illness, injury or medical appointment of an employee's child, spouse, sibling, parent, mother-in-law, father-in-law, domestic partner, grandchild, grandparent, or step-parents for reasonable periods of time as the employee's attendance may be necessary. Sick days may not be transferred from one employee to another. Accrued sick days will be paid starting with the first day of sick leave absence.

Employees going on leaves of absence for medical purposes must use all accrued sick days and other paid time accumulated benefits prior to commencement of the leave, unless otherwise provided for by law.

Accrued sick day benefits may be used by an employee to cover the three (3) day waiting period of a workers' compensation injury. If the recovery from the injury exceeds the three (3) days and the injury is to be covered by workers' compensation, employees who have received sick pay from the County for those three (3) days and are receiving worker's compensations shall reimburse the County the sick pay paid and the employee's sick pay accrual will be reinstated. In no case will sick leave be paid for lost time covered by workers' compensation.

Payment for sick days will not be made unless authorized by the Elected Official or Appointed Department Head. Elected Officials or Appointed Department Heads will monitor utilization of sick days on a pay period by pay period basis. Employees who abuse the use of sick days are subject to corrective discipline.

Department heads may require a physician's certification of the need to take sick leave. Employees who are absent for three (3) or more consecutive days must provide a physician's certificate to return to work. FMLA must be applied for any illness/injury that is expected to last more than three (3) days and requires that all sick leave be used before the employee is allowed to take unpaid leave. Failure to provide such certification may be the basis for denial of sick leave and the equivalent reduction in pay for the time absent from work when applicable. If any employee resigns or is terminated, no lump sum payment of accrued sick pay benefits will be due or paid.

Abuse of the sick leave policy in any manner including but not limited to: failure to take sick leave when needed, taking sick leave for purposes other than its intended to use, and/or falsifying illness or injury shall be the basis for disciplinary action up to and including termination.

Upon retirement, an employee may apply all accrued sick leave toward retirement in accordance with the Illinois Municipal Retirement Fund, 40ILCS 5/7-101 et seq. The maximum amount to accrue beyond sixty (60) days is stated in each labor agreement. Excluded (non-bargaining unit) employees may accrue an additional 240 days for retirement purposes under 40ILCS 5/7-139(a)(8).



Bereavement Leave

Should a death occur in the immediate family of a regular full-time employee, the Elected Official or Appointed Department Head shall give the employee up to three (3) paid days off, as requested by the employee.

For the purposes of this section, “immediate family” is defined as the spouse, son (including step-son), daughter (including step-daughter), brother, sister, mother (including step-mother), father (including step-father), mother-in-law (including step mother-in-law), father-in-law (including step father-in-law), daughter-in-law, son-in-law, grandparents (including step-grandparents), and grandchildren (including step-grandchildren) of the employee.

The County reserves the right to request satisfactory evidence of death and relationship from the employee. If the employee makes a false claim of death or proof of familial relationship, the employee shall be subject to disciplinary action up to and including discharge from employment. Employees do not accumulate Bereavement Leave from one fiscal year to the next, and there is no payment for unused Bereavement Leave.

Paid Time Off (PTO) Under Illinois Paid Leave for All Workers Act (PLFAWA)

Effective on January 1, 2024, pursuant to and in accordance with the Illinois Paid Leave for All Workers Act (“the Act”), all County employees (including full-time, part-time, seasonal, and salaried) shall be provided with up to 40 hours of Paid Time Off (PTO) during the twelve (12) month period from January 1st to December 31st each calendar year. Full-time employees shall be provided with 40 hours of paid time off (PTO) at the start of the fiscal year, and for those employees working part-time, the total number of PTO hours shall be determined on a pro rata basis based on the number of hours the employee works each week.

Employees may use the PTO hours for any reason or purpose the employee chooses, so long as the use of PTO is taken in accordance with the Paid Leave for All Workers Act and the notification requirements of this Policy.

NOTE: Neither this Policy nor the Illinois Paid Leave for All Workers Act shall be applicable to employees

covered by a collective bargaining agreement, which is in effect on January 1, 2024. Upon the expiration of any such collective bargaining agreement, the requirements of the Illinois Paid Leave for all Workers Act may be the subject of bargaining and waived by agreement of the employer and bargaining unit.

Family Bereavement Leave Act (FBLA)

The Family Bereavement Leave Act (FBLA) went into effect on January 1, 2023, expanding unpaid leave rights for employees in Illinois. It is the intent and purpose of this policy that all County employees are eligible for all benefits provided under the FBLA.

The Family Bereavement Leave Act (FBLA) is an amendment to the Child Bereavement Leave Act (CBLA) that expands leave time requirements to cover pregnancy loss, failed adoptions or surrogacy agreements, unsuccessful reproductive procedures, and other diagnosis or events negatively impacting pregnancy or fertility. The FBLA also requires employers to provide leave time after the loss of family members previously not covered by the CBLA, including spouses, domestic partners, siblings, grandparents, and stepparen



Blood Donation Leave Act

Full-time employees with at least six (6) months of service may take up to one (1) hour with pay, or more if approved by their supervisor, to donate or attempt to donate blood once every 56 days in accordance with appropriate medical standards established by the American Red Cross, America's Blood Centers, the American Association of Blood Banks, or other nationally recognized standards. Leave will not be deducted from the employee's vacation, sick, or personal days.

In order to use Blood Donation Leave, the employee must request and obtain the Elected Official or Appointed Department Head approval with as much advanced notice as possible to avoid work disruption.

The Elected Official or Appointed Department Head may require an employee to provide confirmation from the blood bank for the requested time off.

Illinois Voting Law

Employees, who are eligible voters, all allowed time off with pay up to two (2) hours between the time of opening and closing of the polls to vote in a general or special election, or at any election at which propositions are submitted to popular vote.

Only those employees whose work hours begin less than two (2) hours after the polls open (in Illinois at 6:00 AM) AND end less than two (2) hours before the polls close (in Illinois at 7:00 PM), are eligible for the two (2) hour paid leave during working hours. For example, an employee who is scheduled to work from 7:30 AM until 5:30 PM would be eligible for paid leave. Conversely, an employee scheduled to work from 9:00 AM until 6:00 PM would be ineligible because their shift does not begin less than two (2) hours after the polls open.

Employees must request leave prior to Election Day to the Elected Official or Appointed Department Head. The requested leave may be denied if not requested before the election. Also, to minimize work conflicts, employers may specify the two (2) hours during the workday that the employee may be absent to vote.

The Elected Official or Appointed Department Head may require an employee to provide proof of eligibility, such as a voter registration card. Employers may not discipline and/or penalize employees for time spent exercising their right to vote.



Tazewell County

HEALTH PLAN

Plan Summary

The employee health plan provides medical, dental and VSP vision insurance coverage to all available qualifying employees and their families. The County provides three health plans: Traditional, Mid-Level and High Deductible Health Plan.

2026 Summary of Benefits



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact your Human Resources department. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the Calendar Year overall deductible ?	For network providers/out-of-network providers combined: \$500 Individual \$1,000 Family	Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care , emergency room, network charges where copayments apply, and prescription drug copayments are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the Calendar Year out-of-pocket limit for this plan ?	For network providers/out-of-network providers combined: \$1,300 Individual \$2,600 Family	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, dental/vision, penalties for failure to obtain preauthorization, ineligible charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.consociate.com or call 1-877-752-3937 for a list of network providers . You can also see aetna.com/asa .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). For services at BJC COE, the deductible and out-of-pocket expenses will be waived.				
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment	40% coinsurance	Telemedicine with MeMD: Call 1-855-636-3669. All other virtual visits covered as any other office visit. Chiropractic Care covered at 20% coinsurance for Network Providers. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
	Specialist visit	\$25 copayment	40% coinsurance	
	Preventive care/screening/immunization	No Charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Office: 20% coinsurance Outpatient: 10% coinsurance	40% coinsurance	Imaging: Preauthorization is required for CT and MRI for non-orthopedic and for PET scans.
	Imaging (CT/PET scans, MRIs)	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Smithrx.com or 1-844-454-5201.	Generic drugs	Retail 30-day: \$12 copayment 90-day: \$24 copayment	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (retail and mail order). Retirees and/or Retiree's spouses eligible for Medicare are not covered by the Drug Program.
	Preferred brand drugs	Retail 30-day: \$30 copayment 90-day: \$60 copayment		
	Non-preferred brand drugs	Retail 30-day: \$50 copayment 90-day: \$100 copayment		
	Specialty drugs	\$50 copayment		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization is required for some outpatient procedures or benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	Facility: \$300 copayment ; After Facility copayment , other providers for emergency services: 10% coinsurance after In Network Deductible		Preauthorization is required if admitted. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	\$75 copayment	40% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Inpatient or Outpatient treatment - Facility	10% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Inpatient or Outpatient: Services, Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% coinsurance	
If you need behavioral health services, or substance use services	Office Visit	\$25 copayment	40% coinsurance	Virtual visit covered as any other office visit.
	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services, Residential, and Partial Day Services	10% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
If you are pregnant	Office visits	\$25 copayment for initial visit	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for some maternity hospital stays. Pregnancy is covered for a dependent daughter.
	Routine Prenatal and Postnatal services	No charge, deductible does not apply	40% coinsurance	
	Non-Routine Prenatal Services, Delivery, and all Inpatient Care	Facility: 10% coinsurance All other: 20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for electric /motorized wheelchairs and for pneumatic compression devices, or benefits could be reduced.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		Employee vision benefit only
	Children's glasses	Not Covered		None
	Children's dental check-up	Not Covered		Covered only if Dental coverage is elected

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Hearing Aids (Except as required under HB2442, effective 10/1/2025)• Long-term care• Non-emergency care when traveling outside the U.S.• Non-network prescription drugs | <ul style="list-style-type: none">• Routine eye care• Routine foot care, except for diabetes• Weight loss programs |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• Chiropractic Care | <ul style="list-style-type: none">• Infertility Treatment |
|---|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Consociate Health: 1-800-798-2422. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this [plan](#) provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$25
Coinsurance	\$775
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,300

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,300

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist & ER copayment	\$325
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$325
Coinsurance	\$395
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,220

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact your Human Resources department. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the Calendar Year overall deductible ?	For network providers/out-of-network providers combined: \$1,000 Individual \$2,000 Family	Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care , benefits where copayments apply, and prescription drug copayments are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the Calendar Year out-of-pocket limit for this plan ?	For network providers/out-of-network providers combined: \$2,000 Individual \$4,000 Family	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, dental/vision, penalties for failure to obtain preauthorization, ineligible charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.consociate.com or call 1-877-752-3937 for a list of network providers . You can also see aetna.com/asa .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). For services at BJC COE, the deductible and out-of-pocket expenses will be waived.				
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment	40% coinsurance	Telemedicine with MeMD: Call 1-855-636-3669. All other virtual visits covered as any other office visit. Chiropractic Care covered at 20% coinsurance for Network Providers. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
	Specialist visit	\$25 copayment	40% coinsurance	
	Preventive care/screening/immunization	No Charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Office: 20% coinsurance Outpatient: 10% coinsurance	40% coinsurance	Imaging: Preauthorization is required for CT and MRI for non-orthopedic and for PET scans.
	Imaging (CT/PET scans, MRIs)	Office: 20% coinsurance Outpatient: 10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at SmithRx.com or 1-844-454-5201.	Generic drugs	Retail 30-day: \$12 copayment 90-day: \$24 copayment	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (retail and mail order). Retirees and/or Retiree's spouses eligible for Medicare are not covered byt the Drug Program.
	Preferred brand drugs	Retail 30-day: \$30 copayment 90-day: \$60 copayment		
	Non-preferred brand drugs	Retail 30-day: \$50 copayment 90-day: \$100 copayment		
	Specialty drugs	\$50 copayment	Not Covered	Covers up to a 30-day supply, Participants must contact SmithRx for assistance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization is required for some outpatient procedures or benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	Facility: \$300 copayment ; After Facility copayment , other providers for emergency services: 10% coinsurance after In Network Deductible		Preauthorization is required if admitted. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	\$75 copayment	40% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Inpatient or Outpatient treatment - Facility	10% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Inpatient or Outpatient: Services, Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% coinsurance	
If you need behavioral health services, or substance use services	Office Visit	\$25 copayment	40% coinsurance	Virtual visit covered as any other office visit.
	Outpatient services	Facility: 10% coinsurance Physician: 20% coinsurance	40% coinsurance	None
	Inpatient services, Residential, and Partial Day Services	10% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
If you are pregnant	Office visits	\$25 copayment for initial visit	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for some maternity hospital stays.
	Routine Prenatal and Postnatal services	No charge, deductible does not apply		
	Non-Routine Prenatal Services, Delivery, and all Inpatient Care	Facility: 10% coinsurance All other: 20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for electric /motorized wheelchairs and for pneumatic compression devices, or benefits could be reduced.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		Employee vision benefit only
	Children's glasses	Not Covered		None
	Children's dental check-up	Not Covered		Covered only if Dental coverage is elected

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Hearing Aids (Except as required under HB2442, effective 10/1/2025)• Long-term care• Non-emergency care when traveling outside the U.S.• Non-network prescription drugs | <ul style="list-style-type: none">• Routine eye care• Routine foot care, except for diabetics• Weight loss programs |
|--|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• Bariatric Surgery | <ul style="list-style-type: none">• Chiropractic care | <ul style="list-style-type: none">• Infertility Treatment |
|---|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Consociate Health: 1-800-798-2422. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this [plan](#) provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-798-2422

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$25
Coinsurance	\$975
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist & ER copayment](#) \$325
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$325
Coinsurance	\$295
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,620

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact your Human Resources department. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the Calendar Year overall deductible ?	For network providers/out-of-network providers combined: \$3,400 Individual \$6,800 Family	Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the Calendar Year out-of-pocket limit for this plan ?	For network providers/out-of-network providers combined: \$6,100 Individual \$8,200 Family	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, dental/vision, penalties for failure to obtain preauthorization, ineligible charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.consociate.com or call 1-877-752-3937 for a list of network providers . You can also see aetna.com/asa .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
The plan includes services at BJC HealthCare Center of Excellence Network (BJC COE). Services at BJC COE will be covered 100% after deductible.				
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Telemedicine with MeMD: Call 1-855-636-3669. All other virtual visits covered as any other office visit. Chiropractic Care covered at 20% coinsurance for Network Providers.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Imaging: Imaging: Preauthorization is required for CT and MRI for non-orthopedic and for PET scans.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Smithrx.com or 1-844-454-5201.	Generic drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (retail and mail order). Retirees and/or Retiree's spouses eligible for Medicare are not covered by the Drug Program.
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply, Participants must contact SmithRx for assistance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required for some outpatient procedures or benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance		Preauthorization is required if admitted.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Physician Charges, Surgery Services, Hospital care	20% coinsurance	40% coinsurance	
If you need behavioral health services, or substance use services	Office Visit	20% coinsurance	40% coinsurance	Virtual visit covered as any other office visit.
	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services, Residential, and Partial Day Services	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for some maternity hospital stays. Pregnancy is covered for a dependent daughter.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required or benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for electric /motorized wheelchairs and for pneumatic compression devices, or benefits could be reduced.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		Employee vision benefit only
	Children's glasses	Not Covered		None
	Children's dental check-up	Not Covered		Covered only if Dental coverage is elected

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Hearing Aids (Except as required under HB2442, effective 10/1/2025)• Long-term care• Non-emergency care when traveling outside the U.S.• Non-network prescription drugs | <ul style="list-style-type: none">• Routine eye care• Routine foot care, except for diabetics• Weight loss programs |
|--|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• Bariatric Surgery | <ul style="list-style-type: none">• Chiropractic Care | <ul style="list-style-type: none">• Infertility Treatment |
|---|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Consociate Health: 1-800-798-2422. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this [plan](#) provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,300
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$1,880
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,180

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,300
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$460
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,760

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,300
- [Specialist & ER coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Tazewell County Dental Plan Summary of Benefits

Calendar Year Deductible for Class 2 and Class 3 Services	
Individual	\$75
Family Unit	\$100
Calendar Year Maximum Benefit for Class 1*, Class 2, & Class 3 Services per person	\$2,000
Calendar Year Maximum Benefit per person for Class 4 Services	\$2,000

*Does not apply to oral exams, prophylaxis (cleaning) or x-rays.

Covered Dental Expenses:	Member pays	Limits
Class 1 Services (Preventive Care)	0%	See Dental Benefits section
Class 2 Services (Repair and Restoration)	20%	See Dental Benefits section
Class 3 Services (Major Dental Repair)	50%	See Dental Benefits section
Class 4 Services (Orthodontics)* *Limited to Dependents under age 23.	50%	See Dental Benefits section

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and Exclusions set forth in this section. Dental and Orthodontic expense benefits are separate from and in addition to the Medical Benefits of this Plan. These benefits are available only if elected by an Employee for himself/herself and eligible Dependents.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a Participant chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the Participant and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Maximum Allowable Charge for an amalgam filling. The patient will pay the difference in cost.

³ These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

Dental Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to the Maximum Allowable Charge.

Class 1 Services ()

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than 2 per calendar year.
2. Periapical x-rays, as required, and bitewing x-rays once 2 per calendar year.
3. Topical application of fluoride for Dependent Children under age 19, but not more than 2 per calendar year.
4. Palliative Emergency treatment of an acute condition requiring immediate care.
5. Full mouth x-rays, but not more than once every 24 months.

Class 2 Services ()

1. Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children under age 18, but not more than.
2. All Medically Necessary x-rays not covered under another class.
3. Panoramic x-rays, but not more than 2 per calendar year.
4. Simple extractions.
5. Endodontics, including pulpotomy, direct pulp capping and root canal treatment.
6. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant upon demonstration of Medical Necessity.
7. Periodontal examinations, treatment, and Surgery.
8. Consultations.

Class 3 Services ()

1. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore Diseased or accidentally broken teeth. Gold foil restorations are not eligible.
2. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth.
3. Repair or recementing of crowns, inlays, bridgework, or dentures and relining of dentures.
4. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
 - a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable.
 - b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.
5. Periodontal scaling.
6. Oral surgery.
7. Post and core.
8. Stainless steel crowns.
9. Veneers, for Dependent Children under age 19 only.

Class 4 Services ()

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

Orthodontic services will be eligible only when provided to covered Dependents who are under age 23 when treatment is received.

1. Preliminary study, including cephalometric radiographs, diagnostic casts, and treatment plan.
2. Fixed and removable appliance placement, and active treatment per month after the first month.
3. Extractions in connection with orthodontic services.

Dental Exclusions and Limitations

The following Exclusions and limitations are in addition to those set forth in the sections entitled "General Limitations and Exclusions," and "Summary of Benefits."

Adjustments. Charges arising from alteration of dimension or occlusion; to address damage arising from abrasion or attrition; splinting and/or temporomandibular joint disturbances.

Administrative Costs. For administrative costs of completing claim forms or reports or for providing dental records.

After the Termination Date. The Plan will not pay for services or supplies furnished after the date coverage terminates. Predetermination of an allowable course of treatment and eligible services (claims for which coverage would be in effect had coverage not terminated) will not extend coverage beyond termination. The Plan will pay for a prosthetic device, crown, such as full or partial dentures, if the preparatory steps (such as an impression) had already initiated and/or been prepared for said device or crown, while the patient was a Participant in the Plan; so long as the device or crown is delivered and installed within two months following termination of coverage, as well as root canal therapy if the Dentist opened the tooth while the patient was a Participant, and treatment is completed within two months of coverage termination.

Anesthetic. Local infiltration anesthetic when billed for separately by a Dentist.

Athletic Mouth Guards. For athletic mouth guards.

Broken Appointments. For charges for broken or missed dental appointments.

Crowns. For crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.

Duplicate X-Rays. Charges for duplicate copies or replication of x-ray or other imaging.

Education. Charges solely arising from instruction provided regarding oral health and/or diet, including a plaque control program.

Hygiene. For oral hygiene, plaque control programs or dietary instructions.

Implants. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants, except first-time non-cosmetic dental implants.

Late Enrollee. Charges Incurred during the first 24 months of coverage applicable to a late enrollee. This Exclusion shall not apply to such claims arising from or due to an Accidental Injury sustained by the Participant. "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

Late Enrollee. Charges Incurred during the first 24 months of coverage applicable to a late enrollee. This Exclusion shall not apply to such claims arising from or due to an Accidental Injury sustained by the Participant. "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

Medical Benefits. For charges covered under the "Medical Benefits" section of the Plan.

Miscellaneous. The Plan does not cover any dental charge, service or supply not provided by a Dentist or Physician unless it is: (1) specifically for non-Experimental services performed at a dental school under the supervision of a Dentist, and only if the school customarily charges patients for its services, or (2) specifically for cleaning, scaling and/or application of fluoride, and is performed by a licensed dental hygienist under the supervision of a Dentist.

Missing Appliances. The cost of replacing lost, missing, or stolen supplies, including implants, appliances, and prosthetics.

Missing Tooth. Charges for partials, bridges, or implants needed due a missing tooth if the tooth was extracted prior to enrolling in this Plan. This Exclusion does not apply for congenitally missing natural teeth.

More Expensive Course of Treatment. The aforementioned rules regarding Medical Necessity, Maximum Allowable Charge, and the least costly yet equally effective treatments shall apply here as well.

Orthognathic Surgery. For Surgery to correct malposition in the bones of the jaw.

Personalization. For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

Replacements. Charges for replacement of any prosthetic appliance, crown, inlay or on lay restoration, or fixed bridge, made within five years after the last placement, exclusive of replacement necessitated by damages caused by an Accidental Injury sustained by the Participant, resulting in damages that are beyond repair.

Splinting. For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

TMJ. Treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint, and appliances.

A Look at Your VSP Vision Coverage

With VSP and TAZEWELL COUNTY, your health comes first.



As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over \$3,000 in savings.

Provider choices you want.

Maximize your benefits at a Premier Program location, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

	Preferred private practice and retail in-network choices
	 

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.


vision care

More Ways
to Save

Extra
\$20
to spend on
Featured Brands[†]

bebe CALVIN KLEIN
COLE HAAN DRAGON.
FLEXON LACOSTE
 and more

See all brands and offers
at vsp.com/offers.

+

Up to
40%
Savings on
lens enhancements[‡]

Create an account today.

Contact us: **800.877.7195** or vsp.com

Your VSP Vision Benefits Summary
TAZEWELL COUNTY and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

12/01/2022



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$0	Every 12 months
ESSENTIAL MEDICAL EYE CARE	<ul style="list-style-type: none"> Retinal screening for members with diabetes Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP doctor for details. 	\$0 per screening \$20 per exam	Available as needed
PRESCRIPTION GLASSES		\$0	
FRAME*	<ul style="list-style-type: none"> \$220 featured frame brands allowance \$200 frame allowance 20% savings on the amount over your allowance \$200 Walmart®/Sam's Club® frame allowance \$110 Costco® frame allowance 	Included in Prescription Glasses	Every 24 months
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children 	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements 	\$0 \$95 - \$105 \$150 - \$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none"> \$200 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every 12 months
EXTRA SAVINGS	Glasses and Sunglasses <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. 		
	Routine Retinal Screening <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 		
	Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

†Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

©2022 Vision Service Plan. All rights reserved.

VSP, Eyeconic, and WellVision Exam are registered trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM



Virtual Urgent Care

How To Use Opyn Live



24 / 7 / 365 access to fast, convenient, and affordable care.

Doctors can be hard to reach, illnesses can occur in the middle of the night, and sometimes you just have a question. In all of these circumstances, and many more, Opyn Live is the easy and affordable solution.

Simple as 1, 2, 3

- 1 Call, Tap, or Click**
Call 1.866.668.6272 or visit live.opynhealth.com to schedule a consultation with a state licensed physician.
- 2 Triage**
You speak to a Care Coordinator who will triage and update your Electronic Health Record (EHR).
- 3 Consult**
You consult with a physician who recommends a treatment plan, and if medication is prescribed, it's sent electronically.

Common conditions

- Cold and flu symptoms
- Sinus problems
- Ear infection
- Allergies
- Urinary tract infection
- Nausea
- Pink eye
- Stomach viruses
- Rashes
- Sore throat
- Acne
- Recommendations
- Second opinions
- ... and much more



70% of low acuity illness can be taken care of **virtually**

When to use Opyn Live

Our goal is to provide you with convenient, affordable healthcare when you need it most - 24 / 7 / 365. You can use Opyn Live:

- When you need care now.
- If you have a health related question, and need professional guidance.
- If you're considering the ER or urgent care center for a non-emergency issue.
- If you're on vacation, a business trip, or away from home.

Visit or call:

live.opynhealth.com

1.866.668.6272



Licensed healthcare providers provide clinical services through medical practices affiliated with Opyn Health and other network providers. Additional or different telehealth requirements may be applicable in certain states; see www.opynhealth.com for full terms and conditions.



Tazewell County

Flexible Benefits

The flexible benefits program gives the employee more choices plus additional spendable income. It is a concept in employee benefits which uses “*before-tax*” dollars to pay for certain eligible benefits, giving the employee the opportunity to decrease taxes while increasing take-home pay. Base earnings stay the same, but since there is less income available to tax, there is more money to spend.

How it works:

An employee must project how much money they plan on spending on medical, pharmaceuticals, dental, vision, and daycare that is found eligible for flexible benefits by the government. A conservative projection is always recommended. That amount is collected into a flexible savings account and the employee is not taxed on that amount.

You will have until March 15 of the next year to incur an eligible expense for the previous year's flex money. The flexible savings does not carry over; claims must be submitted by March 30 of the following year, and money not used is lost. That is why it is very important to have a conservative amount projected. Enrollment is opened every year during December. Employees may change the amount within 30 days after a qualifying event such as marriage, divorce, the birth or adoption of a child, etc.

The Flex Medical Spending Account is only available when enrolled in the Traditional and Mid-Level PPO option.

Health Savings Account

The Health Savings Account is similar to the Flex Medical Spending Account and is only available when enrolled on the Qualified High Deductible Plan option. The HSA also uses “*before-tax*” dollars to pay for certain eligible benefits, giving the employee the opportunity to decrease taxes while increasing take-home pay when making pre-tax contributions through payroll deduction. Base earnings stay the same, but since there is less income available to tax, there is more money to spend.

How it works:

An employee must open a Health Savings Account at a financial institution that offers HSAs. Provide the direct deposit information to HR and choose your bi-weekly deduction amount. HSA elections can be made at any time during the year up to IRS annual maximum. Alternatively, the employee can choose to make HSA contributions to their account completely outside of payroll and claim the contributions at tax filing time. Unlike a Flex Medical Spending Account, the money in the HSA rolls over from year to year and the employee maintains control of the account.

The employee should familiarize themselves with the IRS rules on Health Savings Accounts at <https://www.irs.gov/forms-pubs/about-publication-969>



Cancer Care

CancerCARE Program Coverage. The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. In order to obtain the best outcomes for Participants, the Plan employs INTERLINK’s CancerCARE Program with specialized care coordination nurses, McKesson Clear Value Plus with Value Pathways powered by NCCN® and NCCN Clinical Practice Guidelines in Oncology®. To be eligible for enhanced Plan benefits, all Participants with a cancer diagnosis must as soon as reasonably possible call the CancerCARE program at **877-640-9610** and complete registration.

CancerCARE Benefits	
Network Providers	
Compliant Benefit	Non-Compliant Benefit
<ul style="list-style-type: none"> • 100% of CancerCARE Allowable covered by Plan; • Participant cancer drug copayments waived; • Certain Course of Care Certification requirements waived for services included in a confirmed Value Pathway; • Participants choosing not to travel to a CancerCARE Provider for complex care, but receiving care in concordance to a Value Pathway; • Clinical Trials as defined below; • Navigator or Compass Participants receiving cancer care when a Value Pathway does not exist if Clear Value Participation has been achieved with NCCN Guideline® concordance or Plan approved deviation; • CancerCARE Second Opinion benefits at 100% of CancerCARE Allowable; • Travel Benefits as defined below. 	<ul style="list-style-type: none"> • Standard Plan Benefits apply as outlined within the applicable Schedule of Benefits.



RETIREMENT

Illinois Municipal Retirement Fund (IMRF)



The Illinois Municipal Retirement Fund (IMRF) provides employees of local governments and school districts in Illinois with a system to pay retirement annuities and disability and death benefits. These benefits are in addition to any benefits provided by Social Security. By working for Tazewell County, IMRF law authorizes and directs the County, as a condition of employment, to make deductions from the employee's earnings. Tazewell County also contributes to the IMRF program on the employee's behalf. Employees contribute 4.5% of their gross pay.

Employees are considered an IMRF participating member if their job requires 1000 or more hours in a year and they are less than 70 years of age at the time the employee was initially employed in a position covered by IMRF. Tier I employees are those who began IMRF participation in 2010 or before. Employees who begin participation on January 1, 2011 or after will have IMRF benefits of Tier II.

All tier employees are eligible to contribute up to an additional 10% of your earnings in the **IMRF Voluntary Additional Contribution** program.

Tier I

- At least eight (8) years of service credit
- At least 55 years of age for partial retirement benefits and at least 60 years of age for full benefits (if the employee worked for at least 35 years, the employee is eligible for full benefits at 55 years of age)
- Participation (there are special provisions for commissioned Deputies)
- Final rate of earnings based on average of highest 48 months in last 10 years of service

Tier II

- At least ten (10) years of service credit
- At least 62 years of age for partial retirement benefits and at least 67 years of age for full benefits (if the employee worked for at least 35 years, the employee is eligible for full benefits at 62 years of age)
- Participation (there are special provisions for commissioned Deputies.)
- Final rate of earnings based on average of highest 96 months in last 10 years of service

Employees should refer to the website www.imrf.org or call **1-800-Ask-IMRF** for more details.



Tazewell County

RETIREMENT

Illinois Municipal Retirement Fund (IMRF) SLEP



The Illinois Municipal Retirement Fund (IMRF) SLEP provides employees of local governments and school districts in Illinois with a system to pay retirement annuities and disability and death benefits. These benefits are in addition to any benefits provided by Social Security. By working for Tazewell County, IMRF law authorizes and directs the County, as a condition of employment, to make deductions from the employee's earnings. Tazewell County also contributes to the IMRF program on the employee's behalf. Employees in the SLEP plan contribute 7.50%

Employees are considered an IMRF participating member if their job requires 1000 or more hours in a year and they are less than 70 years of age at the time the employee was initially employed in a position covered by IMRF. Tier I employees are those who began IMRF participation in 2010 or before. Employees who begin participation on January 1, 2011 or after will have IMRF benefits of Tier II.

All tier employees are eligible to contribute up to an additional 10% of your earnings in the **IMRF Voluntary Additional Contribution** program.

Tier I SLEP

- At least twenty (20) years of service credit
- 50 years of age for full benefits
- Slep Pension is not subject to reduction
- Final rate of earnings based on average of highest 48 months in last 10 years of service

Tier II SLEP

- At least ten (10) years of service credit
- At least 50 years of age for partial retirement benefits and at least 55 years of age for full benefits (Slep pension is reduced 1/2% for each month under age 55)
- Overtime wages are not included in IMRF SLEP contribution.)
- Final rate of earnings based on average of highest 96 months in last 10 years of service

Employees should refer to the website www.imrf.org or call 1-800-Ask-IMRF for more details.



Tazewell County

Deferred Compensation

A 457(b) Deferred Compensation Plan is an IRS approved method for deferring federal and some state income taxes on savings until retirement. These optional retirement plans are similar to the 401k plans in the private sector. Employees choose an amount to be deducted from their paycheck and deposit it into an account in his or her name. Taxes are not paid on these funds at time of contribution, enabling the employee to contribute a greater amount than if contributed before taxes. However, taxes are paid on the savings and earnings when withdrawn, usually during retirement when the employee is presumably in a lower tax bracket. The following IRS guidelines apply for deferred compensation plans:

Age 49 or less

Maximum annual deferral: 100% of salary *or* \$22,500, whichever is less

Age 50 or over

Maximum annual deferral: 100% of salary *or* \$30,000, whichever is less

There is also a Three Year Catch-up which allows the basic annual limit plus the amount of the basic limit not used in prior years (must be within 3 years of retirement without penalties and cannot utilize age 50 or over catch-up contributions). Refer to IRS guidelines for more information. Must be payroll deducted.

The County offers 457 deferred compensation plans through 4 different providers:

NATIONWIDE

Contact Person: Mike Bobell: Email: bobelm1@nationwide.com; Phone: (360) 927-5380

IPPFA/NPPFA

Contact Person: Joel J. Babbitt: Email: joelb@nppfabenefits.org; Phone: (773-427-2060

COREBRIDGE

Phone: 1-800-448-2542

SECURITY BENEFITS/UNLAND

Contact Person: Chad Arseneau: Email: Chad@unlandwealth.com; Phone: (309) 642-6827



Tazewell County

EMPLOYEE ASSISTANCE PROGRAM (EAP)

An Employee Assistance Program (EAP) is available to employees and family members.



An EAP is a professional service to help resolve problems affecting employees' personal lives and jobs including:

- Family, group, & individual counseling
- Divorce, separation, & remarriage
- Family conflicts: aging parents, blended families, children & teen problems
- Financial problems
- Parenting
- Depression & anxiety
- Sexuality
- Low self-esteem
- Physical & sexual abuse
- Addictions counseling
- Eating disorders
- Adult children of alcoholics
- Stress management & career issues

When a problem is too difficult, an employee can simply call TELUS Health. EAP counselors are available 24 hours a day, 7 days a week at (800) 433-7916 or visit the website: one.telushealth.com: Username: tazewell; Password: eap. The EAP offers a private and confidential visit with an experienced counselor, discussion of the problem, and a plan of action.



Tazewell County

VOLUNTARY BENEFITS

IMRF Insurance Products

Employees automatically receive some disability insurance as a benefit of their participation in IMRF. Also, IMRF offers supplemental survivor's benefit and insurance plans through the National Conference on Public Employee Retirement Systems (NCPERS). For \$16.00 a month, which is deducted directly from the employee's paycheck, the employee will be guaranteed a decreasing term life insurance policy. Contact the Human Resource Department at 309-478-5813 for further information.

AFLAC Insurance Products

AFLAC is Tazewell County's Voluntary Insurance provider. They offer a wide range of voluntary insurance products including:

- Life Insurance
- Disability Income Protection Insurance
- Accident Insurance
- Cancer Insurance
- And many others

These benefits are available to the employee via payroll deduction. To learn more, call the AFLAC representative, Ryan Beyer at (309) 357-9030.

CIGNA A&D INSURANCE

Accident insurance can help you pay expenses if you or your spouse is seriously injured or killed in a covered accident. This coverage can help ensure that tragedy does not take both an emotional or financial toll on your family.

By purchasing this insurance product through Tazewell County, you benefit from: Affordable group rates and Convenient payroll deduction.

LegalShield Services

Tazewell County offers payroll deduction that provides protection to the employee and his or her family with a pre-paid legal plan (LegalShield) and identity theft protection (IDShield). Employees should contact Jen Carpenter (jencpta55@gmail.com) at (815) 546-1897, Rob Wheelut (rhwheelut@icloud.com) or Dave Hall (ppldave@gmail.com) at (801) 922-0000.



Tazewell County

EMPLOYEE DISCOUNTS (Continued)

Health Club Discounts

Many of the area health clubs offer special corporate rates for all County employees. Employees will need to check with the health club of choice to see what rates are offered. Need to show employee ID.

Sampling of eligible Health & Fitness Clubs:

Parkside Athletics, Pekin Landmark Health Club Good Hope Complex
Eastside Center, East Peoria River Plex Tremont Area Park District
YWCA Pekin



Tazewell County

DIRECT DEPOSIT

Employees can have their paychecks directly deposited into a bank of their choice.

SYMETRA LIFE INSURANCE

Tazewell County offers their full-time employees a \$25,000 life insurance policy with a no premium cost to the employee. It includes AD&D coverage of \$25,000. Portable supplemental coverage available for additional cost to the employee.

WELLNESS OFFERS TO EMPLOYEES

The wellness programs are free to the employees which includes the following:

- Health Fair to include:
 - Bloodwork (Metabolic panel, lipid panel and CBC)
 - Biometrics (Height, weight and blood pressure)
- Flu Shot Clinic each year given by the Tazewell County Health Department



Tazewell County

PROFESSIONAL DEVELOPMENT

Objective

The purpose of this policy is to provide employees with professional development opportunities that increase their skills and enhance their contributions to the county. An employee's work performance is vital to the success of the county. Providing professional development for our employees is an investment in their careers and the county's future.

Eligibility

Full-time employees are eligible for reimbursement for education costs that are approved by the county.

Eligible Expenses

It is the employee's responsibility to seek out the courses and other training mediums that will enhance his or her career development and are in line with the county's mission. Professional development can be obtained through educational courses, certification programs, or degree programs that will assist the employee in performing his or her essential job functions and increase the employee's contribution to the county. Books and computer-based resource fees are also included.

Procedure

Employees must request permission from their immediate supervisor for approval to participate in the Professional Development Program and to receive reimbursement. This approval must be prior to the start date of courses. Requests and supervisor approval will need to be submitted to Human Resources with applicable course of study, purpose, job relevance, cost, dates, and the name of the institution or source of training for funding validation.

Reimbursement

Upon satisfactory completion of courses the employee must provide documentation of grades of a "C" or better or in a pass/fail grading system a successful "pass". Employee must provide documentation to Human Resources to document completion and receipts regarding payment to receive reimbursement. Receipts should be submitted in a timely manner. The maximum reimbursement amount will be \$5,000 per calendar year.

Payback Requirements

As a matter of record, employees accepting the terms of this policy will be required to sign a written agreement to remain with the county for two years from the date of the educational reimbursement. If the employee terminates within that year, he or she will be required to repay the county for all reimbursements paid.