

City of Springfield Benefit Guide 2026 Plan Year



You & Your Benefits

A partnership for good health



Welcome

Your City of Springfield Benefits

We recognize how important benefits are to you. That's why we're committed to supporting your overall wellness with a comprehensive benefits program designed to meet your unique needs. Key features of your City of Springfield benefits include:

- Choice among many popular benefit options
- Effective and affordable health care coverage
- Programs to help ensure financial security for you and your family
- Wellness support to help live a balanced and fulfilled life

Eligibility

- Full-time employees (30+ hours / week).
- Eligible on date of hire and must choose benefits within 31 days of hire date.
- Variable-hour employees - Must average at least 30 hours/week.
- Eligible dependents - Includes spouse, civil union partner, children up to age 26 and disabled dependent children of any age who meet plan criteria.
- Documentation is required for all dependents, including a social security card, birth certificate (children only) and a marriage or civil union partner certificate.

Effective date of coverage

For new employees, the effective date of coverage for most plans is the date of hire.

Important Reminders

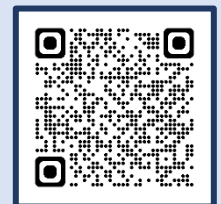
New employees have 31 days from date of hire to enroll in benefits. After your enrollment opportunity ends, you will not be able to make changes to your benefits until the next Open Enrollment, unless you experience a qualifying life event such as marriage, divorce, birth, adoption, or a change in your or your spouse's employment status that affects your benefits eligibility. Qualified Life Events need to be reported to Human Resources within 30 days of the event.

Enrollment

Detailed enrollment information is listed within this guide. Enrollment is submitted via an online portal.

All benefits are available to you on the City's Intranet site, Employee Self Service (ESS) site and on the City of Springfield's public site.

Intranet: <http://wwwint.cwlp.com/>
ESS: <https://ess.springfield.il.us/>
Public site: <https://www.springfield.il.us/>



Benefits Overview

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The City of Springfield offers comprehensive benefits to meet the needs of you and your family. Below is a comprehensive list of the current benefit offerings. Please review this guide to understand your new hire benefits. Additional information is always available on Employee Self Service (ESS). A full contact list is available within this guide.

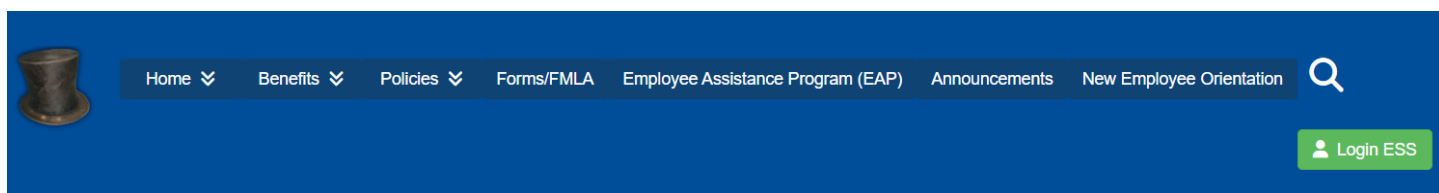
Benefit Options	Carrier
Medical Plan Network & Claims	Aetna Health
Prescription Drug	CVS Caremark / Aetna Health
Clinic	Memorial Health
Dental Insurance	Aetna Health
Vision Insurance	MetLife
Life Insurance and Accidental Death and Dismemberment	MetLife: Basic and Supplemental Life and AD&D NCPERS: Supplemental Life through Pension
Ancillary Benefits Accident, Critical Illness, Hospital Indemnity, Cancer Insurance	MetLife
Disability Insurance	Short-term Disability: UNUM Long-term Disability: MetLife Temporary & Total/Permanent: IMRF
Flexible Spending Accounts - Health FSA - Dependent Care	Optum
Health Savings Account (HSA)	Inspira
FMLA (Family Medical Leave)	MetLife
Fitness Club	FitClub
Pet Insurance	MetLife
Employee Assistance Program	Memorial Health EAP
Pension	IMRF
Deferred Compensation	NPPFA Equitable Valic Horace Mann VOYA

Benefit Resources

Employee Self Service (ESS)

The City of Springfield, Illinois, offers an Employee Self Service (ESS) portal for its employees to access and manage personal and employment-related information. Through the ESS portal, employees can view and update personal details, monitor leave balances, access pay advices, manage tax withholdings, and enroll in or modify direct deposit settings.

Without needing to login you have an abundance of benefit resources at your fingertips. We recommend this as your first stop to gather information regarding, health benefits, retirement options, flexible spending, FMLA and supplemental benefits.



Human Resources Benefits Team

Your City of Springfield Benefits Team is here to help. Whether it be a question on your enrollment, the benefit offerings or to let us know about an issue.

Benefits Specialists

Lashonda Caldwell – Lashonda.caldwell@springfield.il.us

Lisa Lowe – Lisa.lowe@springfield.il.us

Benefits Senior Manager

Kelley Martin – Kelley.martin@springfield.il.us

Human Resources

humanresources@springfield.il.us

217-789-2446



Contact Information

Benefit	Vendor	Phone	Website
Medical			
	Aetna Health Customer Service Pre-Certification, Hospital Admissions, Prior Approval	833-821-8558 888-632-3862	aetna.com
Pharmacy Services			
	CVS Caremark	888-792-3862	aetna.com
Near-Site Clinic			
	Memorial Choice Nurse Concierge	217-862-0669	
Health Savings Account			
	Inspira Financial		mybenefits.inspirafinancial.com
Flexible Spending Accounts			
	Optum Financial	888-339-3685	www.optumfinancial.com
Dental			
	Aetna	877-238-6200	MyAetnaWebsite.com
Vision Insurance			
	MetLife	800-GET-MET8	www.metlife.com
Life Insurance			
	MetLife (Basic and Supplemental)	800-GET-MET8	www.metlife.com
	NCPERS	800-525-8056	Ncpers.org
Voluntary Benefits			
	MetLife (Accident, Critical Illness, Hospital Indemnity, Cancer, LTD)	800-GET-MET8	Metlife.com/mybenefits
Short-Term Disability			
	UNUM	866-679-3054	www.unum.com
Pension			
	IMRF Pension & Disability	800-ASK-IMRF	www.imrf.org
Wellness Benefits			
EAP	Memorial Health	217-788-9345	Memorial.health/memorialeap
Fitness	FitClub	217-787-8348	Fitclub.net
Pet Insurance	MetLife	833-532-2617	Metlifepetinsurance.com

Insurance Benefits

- Medical Insurance
- Health Savings Account
- Medical Flexible Spending Account
- Memorial Care – Near-Site Clinic
- How to Find Care and Save Money
- Prescription Drug Program
- Dental Insurance
- Vision Insurance



Medical Insurance

Quality health coverage is one of the most valuable benefits provided by the City of Springfield. Our benefits program offers plans to help keep you and your family healthy while providing important protection in the event of illness or injury.

As an employee you have a choice of two medical plans with a range of coverage levels and costs. This gives you the flexibility to choose what is best for your needs and budget. The right plan depends on your health care needs, budget and comfort with risk. The POS plan offers more predictable costs, while the HDHP features lower premiums and tax-advantaged savings for those with fewer medical needs.

All medical plans offer:

- Comprehensive coverage for a wide range of health care services.
- Free in-network preventive care, with services such as annual physicals, recommended immunizations, well-woman and well-child exams, and routine cancer screenings covered at 100%.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.
- Choice of two coverage levels: Employee Only or Family.
- A wellness discount for employees that participate in the Health Risk Assessment.

Plan Options

POS (Point of Service)

- A managed-care health insurance plan where you contribute a higher paycheck premium but reduces financial responsibility when you need care with a lower deductible, coinsurance and in-network out-of-pocket maximums.

HDHP (High Deductible Health Plan)

- A high-deductible health plan with lower paycheck contributions, but higher deductibles and out-of-pocket costs.
- Includes a tax-free HSA to help pay for eligible health care expenses, with no “use it or lose it” rule and a City of Springfield contribution once requirements are met.

Which Plan is best for me?

1. Consider your and/or your family's needs.
2. Review the coverage options to determine the amount of coverage you need.
3. Check the premiums, co-payments and deductibles.
4. Check the provider networks to see if your current providers are in-network or determine if you are willing to change providers.

Save 10% on Your Health Insurance Premiums!

Complete an annual Health Risk Assessment (HRA) and Biometric Screening to receive a 10% discount on your health insurance premiums. For detailed information on how to take advantage of this great City of Springfield benefit, please refer to the Memorial Choice section of this guide.

Compare Medical Plans

Choice of plan options: March 1, 2026 SUMMARY ONLY - see Summary of Benefits in the Benefits Guide or Plan Document for details on ESS https://ess.springfield.il.us/	High-Deductible Health Plan (HDHP) Single \$500 HSA Contribution Family \$2,250 HSA Contribution	Open Access / POS Plan
Network:	Choice POS II	Choice POS II
Deductible (Member responsibility) Individual (In-Network / Out-of-Network) Family (In-Network / Out-of-Network)	\$3,400 \$6,800 \$6,800 \$13,600 Includes Medical and Rx	\$400 \$550 \$1,200 \$1,650
Coinsurance (Co-ins (%)) – Member responsibility In-Network / Out-of-Network	N/A / 80%	25% / 30%
Out-of-Pocket Max (Member responsibility) Individual (In-Network / Out-of-Network) Family (In-Network / Out-of-Network)	\$3,400 \$13,600 \$6,800 \$27,200 Includes Medical and Rx	\$1,400 Unlimited \$4,200 Unlimited Includes Medical Deductible and Medical Copays and Co-ins
Physician Services (In-Network) Well Adult / Well Child Physician Office Visit Specialist Office Visit (Referrals not required) X-Rays Diagnostics Urgent Care Labs Outpatient	Plan pays 100% Deductible; then plan pays 100% Deductible; then plan pays 100% Deductible; then plan pays 100% Deductible; then plan pays 100% Deductible; then plan pays 100%	Plan pays 100% \$30 copay; deductible; then Co-ins \$50 copay; deductible; then Co-ins \$50 copay; deductible; then Co-ins \$50 copay; deductible; then Co-ins \$100 copay; deductible; then Co-ins
Mental Health Outpatient Services Inpatient Services	Deductible; then plan pays 100% Deductible; then plan pays 100%	\$30 copay; deductible; then Co-ins Deductible; then Co-ins
Inpatient Hospital Stay (& member pays co-ins) (per admission) In-Network	Deductible; then plan pays 100%	Deductible; then Co-ins
Outpatient Surgery (& member pays co-ins (%)) (In-Network) Facility Fee Physician/Surgeon Fees	Deductible; then plan pays 100% Deductible; then plan pays 100%	\$50 copay; deductible; then Co-ins Deductible; then Co-ins
Emergency Room	Deductible; then plan pays 100%	\$250 copay; deductible; then Co-ins
Pregnancy Office Visits Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services	Deductible; then plan pays 100% Deductible; then plan pays 100% Deductible; then plan pays 100%	\$30 copay/visit Deductible; then Co-ins Deductible; then Co-ins
Hearing Aid	Max \$2,500/device every 24 mos.	Max \$2,500/device every 24 mos.

Choice of plan options: March 1, 2026	High-Deductible Health Plan (HDHP)	Point of Service (POS)
Diabetes Physician Office Visit Specialist Office Visit Supplies (Durable Medical Equipment)	Deductible; then plan pays 100% Deductible; then plan pays 100% Deductible; then plan pays 100%	\$30 copay; deductible; then Co-ins \$50 copay; deductible; then Co-ins Deductible; then Co-ins
Prescription Drugs (Retail –34 days) Generic / Formulary / Non-Formulary <u>Note:</u> Higher copays apply for retail 84-90 days; see full details on Employee Self Service within the Benefit Booklet.	In-Network Deductible; then pays 100% Out-of-Network: No Coverage	<u>Rx Deductible:</u> \$50 individual /\$150 family <u>Max out-of-pocket for Rx Cost:</u> In-Network: Rx Individual \$1,000/ Rx Family \$3,000 Out-of-Network Rx-No Coverage <u>In-Network Copays:</u> \$15 / \$25 / \$45 / \$50
Prescription Drugs (Mail Order –90 days) Generic / Formulary / Non-Formulary	In-Network Deductible; plan pays 100% Out-of-Network: No Coverage	<u>In-Network Only Copays:</u> \$37.50/ \$62.50 / \$112.50 (Rx Deductible and Max Rx out of pocket applies-see Rx above)
Lifetime Maximum	Unlimited	Unlimited

What does this mean?

- **Point of Service Plan (POS):**
 - In-network benefits – If you get services from an Aetna provider, in-network benefits apply.
 - All other services will be considered out-of-network.
- **High-Deductible Health Plan (HDHP):**
 - In-network benefits – If you get services from an Aetna provider, in-network benefits apply.
 - All other services will be considered out-of-network.
- **Premium** – The amount deducted from your payroll each pay period.
 - Premiums will be deducted on the first two checks of each month – 24 pay periods total.
- **Copayments** – Fixed fees for office visits, prescriptions or other care, paid at the time of service.
- **Deductibles** – The costs you pay before your insurance kicks in.
- **Coinsurance** – The percentage you pay for your service after the deductible is met.
- **Out-of-pocket maximums** – The maximum you'll pay for covered services in a plan year. After reaching this, insurance covers 100% for the remainder of the plan year.



How to Get Care and Save Money

Use In-Network Doctors

- For the lowest cost, always use in-network doctors, clinics, hospitals and pharmacies.
- Out-of-network care will cost you more because the plan covers less.

Choose the Right Type of Care

- Memorial Choice Near-Site Clinic
 - FREE for City of Springfield employees and their families who are enrolled in a City medical plan
- Virtual Visits or Doctor Visits
 - Quick, convenient, and often cheaper.
- Use Your Preventive Care Benefits
 - Preventive Care: Annual exams like physicals and well-woman exams are 100% covered when you visit an in-network doctor.
 - These exams can help catch health issues early saving you money in the long run.
- Urgent Care vs. Emergency Room
 - Urgent Care visits are generally cheaper because they handle less severe medical issues.
 - Choosing the right location can help save money.

Emergency Room vs. Urgent Care

Ask yourself: Is it life-threatening?

Life-Threatening » Emergency Room

Breathing problems or shortness of breath
Chest pain
Severe, wide-area burns
Broken bones that stick out
Large, deep wounds
Uncontrolled bleeding
Severe pain
Paralysis or numbness/weakness of limbs
Head or eye injury
Poisoning or overdose
Unconsciousness

Not Life-Threatening » Urgent Care

Fevers, cough, congestion, or headaches
Back, muscle, or mild abdominal pains
Minor burns
Sprains, pulled muscles, or other minor injuries
Abscesses or small lacerations
Urinary tract infections
Rashes or skin conditions
Flu, COVID-19, strep testing
Ear aches or eye infections
Nausea, vomiting, or diarrhea
Animal or insect bites

Prescription Drugs

- Ask about Generic Drugs
 - Always ask your doctor if a generic version of the prescribed medication is available.
- Find Lower Prices
 - Take advantage of prescription savings programs at major retailers or directly through the manufacturer.
 - GoodRx (goodrx.com) can help you find the lowest prices at local pharmacies.

Claims Administrator and Health Network

The City of Springfield is a self-funded employer, meaning the City pays health claims directly, while Aetna manages claims processing, customer service and the provider network. Aetna will serve as both the health plan administrator and the provider network for the City of Springfield's medical plans.

What Aetna Does for You

- Processes medical claims
- Provides access to the Aetna provider network
- Offers member tools to manage benefits and costs
- Supports members through customer service and digital resources

MyAetnaWebsite.com is your place to:

- See virtual ID cards or to request a new ID card
- Access your benefits and claims information
- Track claims, deductibles and out-of-pocket costs
- See estimated costs before receiving care
- Access virtual care options
- Receive secure messages and opt in for electronic communications
- View links to plan networks, online member portal guide and so much more!

Finding Aetna In-Network Providers

- To find an in-network provider, go to Aetna.com and at the top of the screen, choose Find a doctor.
- Under Guests, choose Plan from an employer.
- Under Continue as guest, enter your zip code and click Search.
- Under Select a Plan, scroll down and select Aetna Choice® POS II (Open Access).
- Click on the radio button for the plan option that you want to see, then click Continue.
- From there you can search for a specific doctor or type of practice. You can also scroll down further to find what you need by category and choose from there

Get started today



Visit MyAetnaWebsite.com to register for your member website.



Get the **Aetna HealthSM app** by texting "**AETNA**" to **90156** to receive a download link. Message and data rates may apply.**

— OR —



Scan the QR code to download the **Aetna HealthSM app**.

Health Savings Account



If you enroll in an HDHP medical plan, you are eligible to open an HSA. A health savings account (HSA) allows you to save money for qualified medical expenses that you're expecting, such as contact lenses or monthly prescriptions, as well as unexpected ones — this year and for any future needs. It's a win-win for saving on health costs today, tomorrow and through retirement.

To be Eligible for an HSA, you must:

- Be enrolled in an HDHP plan.
- Not be covered by any other medical plan that is not a high deductible health plan. This includes a spouse's medical plan.
- Not be enrolled in Medicare, including Part A.
- Not be claimed as a dependent on another person's tax return.
- Not be enrolled in a traditional health care FSA (your own or your spouse's)

Advantages of having an HSA

- Pre-tax contributions that grow tax-free and can be used tax-free for qualified expenses.
- Lower premiums for the plan.
- No cap on unused funds that roll over each year.
- Portable if you change jobs or retire.
- Invest funds (after a minimum balance).
- Pay for medical, dental, and vision expenses for you and your family.

* Note: Ineligible withdrawals are taxed and penalized. See IRS Publication 502, available at www.irs.gov).

Steps to using your HSA

1. Show your insurance ID card to your doctor.
2. The doctor submits your services to the carrier for discounts.
3. The carrier applies network discounts.
4. You will receive an Explanation of Benefits (EOB) from the carrier.
5. Compare the EOB with the doctor's invoice to ensure they match.
6. Pay the doctor using pre-tax HSA dollars and/or funds from your pocket if funds are low.

Qualified Expenses for your HSA

- Doctor's office visits and procedures
- Acupuncture, chiropractic care and medical devices (e.g., blood pressure monitors, blood sugar kits)
- Dental cleanings, exams, crowns and bridges
- Eye exams, glasses, contacts and corrective surgery
- Prescription drugs and OTC medications
- Certain medical equipment

Inspira Financial

Inspira HSA Accounts

- Inspira HSA accounts will be automatically set up for all employees who enroll in an HDHP
- You do not need to open an HSA on your own to participate
- HSA funds roll over year to year and remain yours even if you change jobs or retire

 **Plan, save, pay on the go with the Inspira Mobile™ app**
Scan the QR code to download the app on iOS or Android.



Download on the
App Store



Get it on
Google Play

City of Springfield Contribution

Employees enrolled in the HDHP may be eligible for a City of Springfield HSA contribution, provided all requirements are met. Requirements include:

- Must be enrolled in the HDHP
- Individual coverage must complete a Wellness Screening and Health Risk Assessment (HRA)
- Screening and HRA must be completed with your Primary Care Physician or at Memorial (additional information on Memorial's Wellness Screening will be available after March 1st)
- Annual screening and HRA must be completed by **December 31 of each year**
- City contributions are deposited after all eligibility requirements are met and the HSA is active

City Contribution Eligibility Requirements

- The employee, if covered as an individual, must complete a Biometric Screening and a Health Risk Assessment (HRA) with Memorial Choice.
- Biometric Screening and HRA must be completed within the first 60 days of hire.
- You must be enrolled in the HDHP health plan.

Important!

- To contribute or receive the City contribution, YOU are required to finalize all documents to open your Inspira HSA account.
- The HRA must be completed before the City's contribution will be made for individual coverage.

2026 HSA Contributions

Coverage Level	City of Springfield Contribution	Maximum Employee Contribution	2026 IRS HSA Limit
Employee Only	\$500	\$3,900	\$4,400
Family	\$2,250	\$6,500	\$8,750

**Catch up Contribution: Employees Age 55+ can contribute an additional \$1,000 to their HSA.*



Medical FSA

Optum

Through Optum Financial, employees are eligible to enroll in a Flexible Spending Account (FSA). An FSA is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical expenses. You choose how much money you want to contribute to an FSA at the beginning of each plan year and can access these funds throughout the year. This contribution is subject to certain legal limits.

Eligibility:

- Full-time employee
- You must not be enrolled in an HDHP plan.
- You must not be covered by any other medical plan that is a high-deductible health plan. This includes a spouse's medical plan.

Access to Funds:

Your FSA funds are available year-round to cover eligible expenses like doctor visits, prescriptions, over-the-counter treatments, physical therapy, and more. Even though contributions are deducted from your paycheck throughout the year, the full amount is accessible as soon as you contribute.

Contribution Limits

Each year, you decide how much money you want to contribute to your FSA, but there are limits on how much you can contribute. Spouses that work at the City of Springfield may each contribute up to the annual COS limit individually.

- The City of Springfield has set a contribution limit of \$2,500 per year for the Health FSA with a minimum contribution of \$120.

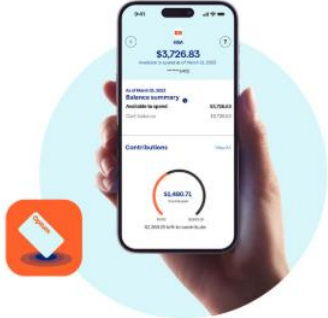
Use-It-or-Lose-It Rule and Carryover:

FSA funds must be spent within the plan year. Unused funds at the end of the plan year are forfeited except for the carryover amount below.

Participants of the Medical FSA will be able to carryover up to \$550 of their unused account balance into the new plan year. Carryover funds must be used by the end of the next calendar year.

[Optum.com/](https://optum.com/) is your place to:

- Access and manage your FSA account.
- View your balance, check recent transactions and track eligible expenses.
- Submit receipts for eligible expense reimbursements.
- Set up direct deposit for faster processing.
- Access tools and resources: calculators, eligible expense lists and other helpful resources.
- Opt in for electronic communications



Unlock your health dollars today

Why wait? Get the app and make your health dollars go further.



Scan to download the Optum Bank app

HSA vs Medical FSA – What’s the Difference?

The choice between the two depends on your health plan, financial goals and how much you anticipate spending on healthcare. While both are tax-advantaged accounts for healthcare expenses, they differ in many ways.

Review the table below for a portion of the differences.

	HSA	FSA
Use for health-related expenses	✓	✓
Pretax contributions	✓	✓
Unused funds roll over to the next year*	✓	✓ *\$550 rollover limit
Funds are forfeited if you leave your job		✓
You can invest the balance	✓	
The account belongs to you	✓	
Need to be enrolled in a high-deductible health plan	✓	
Cannot be enrolled in Medicare	✓	
Can be a retirement account	✓	
100% of elected amount is available day one		✓
Contribution Limits for 2026	\$4,400 (individual) \$8,750 (family) \$1,000 catch-up for 55+	\$2,500 (individual or family)

In summary:

- **HSAs** offer more long-term flexibility, allowing funds to roll over year to year, and can be used for retirement savings if needed.
- **FSAs** are shorter in nature, with a "use-it-or-lose-it" policy, but they are available to anyone, regardless of the type of health plan they have.

How do I choose what is best for me?

When deciding between an HSA and FSA, consider your health insurance plan, anticipated medical expenses and employment. Below are some questions to consider:

- Which health insurance plan do I plan to choose?
- What are my anticipated medical expenses, including prescriptions?
- How much do I plan to or can afford to contribute?
- What are my investment goals for retirement?
- Do I plan to use this account for long-term savings?

The City of Springfield offers expanded healthcare access through **Memorial Choice**, providing medical plan members with convenient, high-quality care at low to no cost. With trusted providers, multiple locations, and \$0-cost options for many routine services, Memorial Choice makes healthcare easier and more affordable for you and your family.

What Is Memorial Choice?

Memorial Choice is a near-site clinic program available to employees and dependents enrolled in the City's medical plan. It does not replace your health insurance—rather, it works alongside your medical coverage to provide additional services at reduced or no out-of-pocket cost.

No separate enrollment is required. If you are enrolled in the City's medical plan, you automatically have access to Memorial Choice benefits.

Why You'll Love Memorial Choice

✓ \$0-Cost Care for Common Needs

With Memorial Choice, you can receive many routine services at no cost, including:

- Select primary care visits
- Urgent care at Memorial Care locations
- Telehealth visits with Memorial providers
- Preventive care and wellness visits
- Select labs and X-rays at Memorial facilities

*Services beyond basic care may be billed according to your medical plan.

✓ Walk-In Urgent Care When You Need It

Feeling sick or injured and can't wait for an appointment? Memorial Choice includes \$0-copay urgent care at Memorial Care locations—no appointment needed. Urgent care clinics are open 7 days a week, with evening hours and on-site lab and X-ray services available.

✓ Extra Support That Makes a Difference

Nurse Concierge – Your Healthcare Shortcut

The Nurse Concierge is a free service available exclusively to Memorial Choice members. One call can help you:

- Schedule appointments
- Determine the right level of care
- Coordinate referrals and prescriptions
- Get answers to healthcare questions

Call 217-862-0669 | Monday–Friday 7:00 a.m.–7:00 p.m.

Download the My Memorial App
to start your health journey.

APP STORE



GOOGLE PLAY



✓ Care Coordination for Complex Needs

Employees and dependents with ongoing or complex conditions can access free care coordination services. Care coordinators serve as personal health advocates to help manage appointments, care and treatment plans.

✓ More Locations = More Convenience

Memorial Choice gives you access to multiple locations across the region, making it easier to get care close to work or home.

Frequently Asked Questions about Memorial Choice

Q. Do I have to Change doctors?

A. Short answer No:

- If you already see a provider with Memorial Medical Group, you're all set.
- If you currently see a provider outside Memorial, you do not have to change—but transferring your primary care to Memorial allows you to access the full Memorial Choice benefits.

Q. How do I choose what type of care I should access?

A. If you're not sure whether primary care, urgent care, telehealth or a visit to the Emergency Department is the best option, call the nurse concierge at 217-862-0669, available 7 a.m.–7 p.m. Monday through Friday. The nurse concierge can schedule a visit with your primary care physician, if appropriate, or help you access telehealth or urgent care.

Save on your health insurance premiums!

To save on your health insurance premiums you are required to complete a Wellness Exam with Memorial Choice or your Primary Care Physician.

New Hire Eligibility Requirements (within 60 days of hire)

Step 1: Complete the Health Risk Assessment

- Download the **My Memorial App** from the app store (or update it to the latest version to access the HRA).
- Build your profile and select **City of Springfield** as your current employer.
- Open the menu (top left three lines) and click **Check My Health**.
- Select your name under “Who is this for?” and choose **Start Your Assessment**.
- Complete the “Where I Am Now” and “Where I Want to Be” sections and submit.

That's it! If you'd like additional support, you can request a call from a nurse care coordinator.

Step 2: Complete your Biometric Screening

Option 1: Work with your Primary Care Provider

- Print the biometric screening form and schedule an appointment.
- Complete labs at the lab of your choice, Memorial laboratory options below.
- Have Primary Care provider submit the completed biometric screening form to MemorialChoice@mhsil.com or fax to (217) 527-3435.

Option 2: Work with Memorial Wellness Center

- Schedule an appointment with Memorial Wellness Center
- Complete labs at any Memorial Laboratory location
- Your biometric exam results will be sent to you and submitted to MemorialChoice@mhsil.com or faxed to (217) 527-3435.

Memorial Choice Location Lists



Location	Address	Phone	Primary Care	Labs	Urgent Care
Memorial Care in Beardstown	8460 St. Luke's Drive Beardstown, IL 62618	217-544-0306	✓		
Memorial Care in Chatham	101 E. Plummer Blvd. Chatham, IL 62629	217-483-3487	✓	✓	✓
Memorial Care on W. Hay	441 W. Hay St. Decatur, IL 62526	217-876-4810	✓		
Memorial Care on E. Maryland	4775 E. Maryland St. Decatur, IL 62521	217-243-0300	✓		
Memorial Care on US 36 East	4455 US Route 36 East Decatur, IL 62521	217-588-2600			✓
Memorial Care in Forsyth	241 W. Weaver Road Forsyth, IL 62535	217-876-5220	✓		
Memorial Care on Founders Lane	15 Founders Lane, Suite 100 Jacksonville, IL 62650	217-243-0300	✓	✓	
Memorial Care on Morton	901 W. Morton Ave., Suite 22 Jacksonville, IL 62650	217-588-6140		✓	✓
Memorial Care in Lincoln	515 N. College St. Lincoln, IL 62656	217-732-9681	✓		
Memorial Care in Petersburg	1 Centre Drive Petersburg, IL 62675	217-632-7761	✓		
Memorial Care on Koke Mill	3132 Old Jacksonville Road Springfield, IL 62704	217-862-0800	✓	✓	✓
Memorial Care on N. Dirksen	3220 Atlanta St. Springfield, IL 62707	217-588-7400	✓		
Memorial Care on South Sixth	2950 S. Sixth St. Springfield, IL 62703	217-588-7450	✓	✓ Drive-Thru	✓
Memorial Lab on Fourth & Carpenter	320 E Carpenter St. Springfield, IL 62702	217-788-3050		✓ Drive-Thru	
Memorial Care in Sullivan	1220 W. Jackson St. Sullivan, IL 61951	217-728-2042	✓		

Prescription Drug Plan



Employees who enroll in a City of Springfield medical plan will have prescription drug coverage through **CVS Caremark**.

Aetna will administer both medical and prescription benefits together, which means:

- Real-time coordination between your doctor, pharmacy and health plan
- Fewer delays and smoother claim processing
- Better support for chronic and complex conditions
- Member Services Call Center – Available 24/7
- Broad Pharmacy Access & Convenience
 - Access to a large national retail pharmacy network
 - Ability to fill 90-day supplies at participating retail pharmacies or by mail through CVS Caremark Mail Service Pharmacies
 - Integrated mail-order and specialty pharmacy services for maintenance and specialty medications
- Specialty Medication Support
 - Dedicated **specialty pharmacy care teams**
 - Clinical support programs for complex conditions
 - Care coordination, refill reminders and patient assistance programs
 - Programs designed to improve safety, adherence and outcomes

Open Access			
Participating Pharmacy Network:	Retail	Retail 90-Day Supply	CVS Mail Order
Generic	\$15	\$45	\$37.50
Formulary	\$25	\$75	\$62.50
Non-Formulary	\$45	\$135	\$112.50
Specialty Medication	\$50, limit 30-day supply for specialty medications		
*If you receive a brand-name medication when a generic is available, you will pay the brand copayment plus the difference in cost between the generic and brand-name medication			
Type of Coverage	Annual Rx Deductible ¹		Annual Rx Out-of-Pocket Maximum ²
Individual Coverage	\$50		\$1,000
Family Coverage	\$150		\$3,000
1. The deductible resets on March 1 st and applies to Open Access Rx prescriptions only (medical does not apply).			
2. The out-of-pocket maximum resets on March 1 st and applies to POS Rx copays only (medical does not apply)			
High-Deductible Health Plan (HDHP)			
Copay	\$0 copay – Pay total cost until medical deduction is met.		
Specialty Medication	Limited to a 30-day supply for specialty medication		
Type of Coverage	Annual Rx Deductible ¹		Annual Rx Out-of-Pocket Maximum ²
Individual Coverage	\$3,300		
Family Coverage	\$6,600		
1. The deductible applies to both medical and prescriptions; once met, prescriptions are \$0 for the remainder of the plan year.			
2. The out-of-pocket maximum applies to both medical and prescriptions; once met, prescriptions are \$0 for the remainder of the plan year.			

Out-of-pocket maximums

Once your pharmacy out-of-pocket expenses reach the specified limit, the plan will cover 100% of covered charges for the rest of the year. Ancillary charges for brand-name medications when a generic is available don't count toward the out-of-pocket maximum. These are separate from your medical plan's out-of-pocket maximum. Check your medical plan summary for details.

Prescription ID Cards

Your medical ID card includes pharmacy processing information.

How to Save on your Prescriptions

- Request two prescriptions from your doctor: one for a short-term (e.g., 34 days) and one for a long-term supply (e.g., 90 days).
- The short-term prescription lets you try the medication for a month. If it works, you can fill the 90-day prescription afterward.
- For refills, the copay for the fourth and any later refills will be the same as the 90-day supply rate.

How to use your plan

There are several ways to fill your prescriptions depending on your needs:

- Short-term medications (e.g., antibiotics, pain relievers): Fill at a participating local pharmacy. Present your Aetna Member ID card and pay the copayment.
- Regular medications (e.g., high blood pressure, diabetes): Fill a 90-day supply via mail order or a participating pharmacy.
- Complex conditions (e.g., rheumatoid arthritis, cancer): Contact Birdi Specialty Pharmacy at 877-437-9012 for help transferring prescriptions.
- Out-of-network pharmacy: Pay full cost and submit a claim for reimbursement within 365 days.

Dental Plan



Maintaining healthy teeth and gums is crucial to your overall wellness. Regular dental checkups, coupled with good oral hygiene, help prevent issues and ensures your smile stays bright and healthy. To support your oral health, the City of Springfield offers dental insurance through Aetna, administered under a PPO plan.

Plan Options:

The City offers two Aetna Dental PPO plan options: Low Plan and High Plan

Both plans use the Aetna Dental PPO network, giving you access to a wide selection of dentists nationwide. Staying in-network helps you receive the highest level of benefits and lower out-of-pocket costs.

Compare Dental Plans

	Low Plan In-Network / Out-of-Network	High Plan In-Network / Out-of-Network
Coverage Type		
Diagnostic & Preventative Care (cleanings, exams, x-rays, fluoride)	100% / 100%	100% / 100%
Basic Restorative Services (fillings, simple extractions, root canals)	80% / 70%	90% / 80%
Major Restorative Services (implants, bridges, crowns, dentures)	50% / 50%	60% / 50%
Orthodontia	50% / 50%	50% / 50%
Deductible		
Individual	\$75 / \$75	\$50 / \$50
Annual Maximum Benefit		
Per Person	\$1,000	\$2,000
Orthodontia		
Services	50% / 50%	50% / 50%
Lifetime Maximum Per Person	\$1,000	\$1,000
Eligibility	Adults and Child(ren) to age 19	Adults and Child(ren) to age 19

**Plan Summary and full plan details are located on Employee Self Service.*



[MyAetnaWebsite.com](https://www.aetna.com/MyAetnaWebsite.com) is your place to:

- View your dental ID card
- Review plan benefits and coverage
- Track claims and dental spending
- Find in-network dentists by name, specialty, or location
- View dentist ratings and reviews
- Get cost information before receiving care*

Extra Savings & Added Value

As an Aetna Dental member, you may have access to:

- **Discounts on oral care products** and wellness services: Save an extra 20% on select products (including sale items), like teeth whitening products, mouthwash, toothpaste and toothbrushes.
- **Virtual dental care through Dental.com**, including online consultations and AI-powered oral health scans
- **Weight management** – save on weight loss programs and meal plans.
- **Healthy lifestyle choices** – Save on gym memberships, health coaching, fitness gear, wearable fitness devices, group classes on demand and more.



To explore savings, scan the code
or visit go.aetna.com/dentaldiscounts

Finding a Dentist

To confirm your dentist is in network:

1. Visit **Aetna.com**
2. Select **Find a Dentist**
3. Choose the **Aetna Dental PPO network**
4. Search by provider name, ZIP code, or specialty



Vision Plan



Vision coverage helps you save on eligible eye care expenses, including routine eye exams, eyeglasses, contact lenses, and more for you and your covered dependents.

Vision Plan Benefits

With the Superior Vision PPO Plan, you can:

- Visit any licensed vision provider
- Choose from a wide network of optometrists, ophthalmologists and retail locations, including Costco Optical, Walmart, Sam's Club, Visionworks, LensCrafters and Target Optical

Out-of-Network

If you choose to receive covered benefits from an out-of-network provider, you will pay in full at the time of service, obtain an itemized receipt and file a claim for reimbursement up to the allowed allowance.

Superior Vision Plan	In-Network	Out-of-Network
Routine Eye Exam (Annual)	\$10 Copay	Reimbursed up to \$45
Eyeglass Frames		
Once every 24 months	\$15 Copay; \$120 Allowance	Reimbursed up to \$55
Eyeglass Lens (instead of contact lenses)		
One pair every calendar year – standard plastic • Single vision lenses • Bifocal lenses • Trifocal lenses	\$15 Copay	Reimbursed up to \$30 Reimbursed up to \$50 Reimbursed up to \$65
Eyeglass Lens Enhancements		
• When obtaining eyewear from a MetLife provider, upgrades are offered at a discount	Discount dependent on enhancement	No allowance when obtained out-of-network
Contact Lenses (instead of eyeglass lenses)		
• Standard Fitting • Specialty Fitting	• \$25 Copay • \$50 Allowance after \$25 Copay	
• Elective (non-disposable) • Elective (disposable)	• \$105 Allowance, then discount off remaining balance	Reimbursed up to \$105

Plan Summary and full plan details are located on Employee Self Service.

Employee Premiums

March 1, 2026 – February 28, 2026

Per Pay Premiums based on 24 pays

Employee <u>MEDICAL</u> Premiums				
	EMPLOYEE ONLY	PLUS ONE	FAMILY	
Open Access	\$98.73	\$164.31	\$226.89	WELLNESS
	\$109.70	\$182.57	\$252.10	w/o WELLNESS
HDHP	\$ 0.00	\$116.95	\$160.68	WELLNESS
	\$ 0.00	\$129.94	\$178.53	w/o WELLNESS
Military (Adult Child Age 26 – 30) Enhanced \$27.45/Basic \$15.00				

The health premiums and/or Plan provisions are subject to change based on the Plan's quarterly review

Employee <u>DENTAL</u> Premiums			
	EMPLOYEE ONLY	EMPLOYEE PLUS ONE	FAMILY
High Plan	\$19.50	\$38.99	\$76.01
Low Plan	\$16.21	\$32.41	\$63.19
Military (Adult Child Age 26 – 30) Enhanced \$27.45/Basic \$15.00			

Employee <u>VISION</u> Premium			
	EMPLOYEE ONLY	EMPLOYEE PLUS ONE	FAMILY
Vision	\$2.70	\$4.71	\$7.52
Military (Adult Child Age 26 – 30) \$2.70			

(Monthly) <u>COBRA</u> Premiums			
	EMPLOYEE ONLY	EMPLOYEE PLUS ONE	FAMILY
OPEN ACCESS	\$1,191.91	\$2,436.42	\$3,364.31
HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)	\$752.80	\$1,505.58	\$2,068.64

Vision and Dental rates remain the current rates when electing Cobra.

COBRA rates are subject to change based on the changes in the entire plan in a quarterly review. COBRA rates are based on the recommendation of an outside actuarial projection. COBRA rates reflect the entire cost of the health program and a 2% administrative fee. Participant coverage is individual and any participant has the right to cancel the beginning of any month. Coverage is up to the maximum described to you by the plan sponsor.

Income Replacement Benefits

- Basic Life / AD&D
- Voluntary Life / AD&D
- Voluntary / Supplemental Benefits
 - Accident
 - Critical Illness
 - Hospital Indemnity
 - Cancer Insurance
- Disability Insurance
 - Short-term Disability
 - Long-term Disability
 - IMRF Disability
- Parental Leave (MAPA)



Life and AD&D Insurance



As a City of Springfield employee, you get life insurance and accidental death and dismemberment (AD&D) insurance through MetLife at no cost to you. You also have the option to buy extra coverage (Supplemental Term Life Insurance and AD&D) for yourself and your family. This extra insurance helps support your loved ones financially if something happens to you.

City Paid Life Insurance and AD&D

The City provides employees with Basic Term Life and Accidental Death and Dismemberment (AD&D) insurance through MetLife at no cost to you. However, the coverage reduces by 35% when you turn 65 and by 50% when you turn 70. There's no cost for you to participate in this plan.

Benefit Amount:

- \$25,000 per employee – Life
- \$25,000 per employee – AD&D

Supplemental Life Insurance and AD&D

Optional additional life insurance coverage, provided by MetLife, is available for eligible employees and their families. This coverage is 100% paid by the employee. You can find contribution rates on the Employee Self Service (ESS) portal or in the Plan Document Guide.

To purchase this extra coverage, you need to enroll through MetLife either by phone or through their online portal. The enrollment details are provided in this section of the guide.

Coverage Options:

	Coverage Increments	Minimum Benefit	Maximum Benefit	Guaranteed Issue Amount <i>(new hire enrollment only)</i>
Employee	\$5,000	\$5,000	\$500,000	\$100,000*
Spouse	\$5,000	\$5,000	\$100,000 <i>(not to exceed 50% of employee's life benefit)</i>	\$30,000*
Child: Under 6 months	\$100	\$100	\$10,000	\$10,000
Child: 6 mos. to 26 yrs.	\$10,000	\$10,000	\$10,000	\$10,000

* **Guaranteed Issue:** As a new hire, you can enroll in supplemental life insurance up to a certain amount without needing to fill out a health questionnaire. This is called "Guaranteed Issue." After the new hire enrollment period, if you or your spouse want to enroll in coverage (or increase the coverage amount), you will need to complete a Statement of Health (SOH) or Evidence of Insurability (EOI). This helps MetLife assess your health before approving the coverage.

Elect or Update Beneficiaries

To ensure your life insurance benefits go where you want them to, make sure to elect your beneficiaries!

MetLife Voluntary Benefits



Ancillary benefits help City of Springfield employees manage out-of-pocket costs not covered by a medical plan. Contribution rates, details, and guides are available on the Employee Self Service (ESS) portal or in the Plan Document Guide. Enrollment information are listed in the enrollment section of this guide.

Ancillary or Voluntary Benefits Available through MetLife:

- Accident Insurance
- Hospital Indemnity
- Critical Illness
- Cancer Insurance

Accident Insurance

Accident insurance is designed to supplement your medical coverage, providing a lump-sum payment for a covered event, no matter what your medical plan covers. This one-time payment can be used however you choose, helping you financially when your family needs it most. It helps pay for medical tests, treatments, services, and care related to accidents.

Benefit Type	Amount Paid
Injuries	
Second and Third Degree Burns	\$50 - \$5,000
Concussion	\$200
Dislocations	\$50 - \$3,000
Fractures	\$50 - \$3,000
Medical Services and Treatments	
Emergency Care	\$25 - \$50
Non-Emergency Care	\$25
Initial Doctor Visit	\$50
Ambulance	\$750 (air) or \$200 (ground)
Hospital Coverage (Accident)	
Hospital Admission (Standard or ICU)	\$500 - \$1,000 per accident
Standard Hospital Confinement	\$100 a day
ICU Confinement	\$200 a day
Other Benefits	
Eye Injury	\$200
Laceration	\$25 - \$200
Physical Therapy	\$15
Health Screening Benefit (Wellness)	\$60 (payable once per calendar year for each family member enrolled)
Lodging	\$100 per night up to 31 nights per calendar year

*See certificate for full benefit details, including restrictions and maximum benefits.

Hospital Indemnity

Hospital Indemnity Insurance helps by providing extra coverage to supplement your medical plan for hospital stays. You'll receive a lump-sum payment that you can use however you need, including covering things your medical plan might not, like deductibles, co-pays, out-of-network care, and everyday living expenses.

Benefit Plan	Admission Non-ICU / ICU	Confinement Non-ICU / ICU
Low Plan	\$500 / \$1,000 (Sickness or per Accident)	\$100 / \$200 per day (up to 31 days)
High Plan	\$1,000 / \$2,000 (Sickness or per Accident)	\$200 / \$400 per day (up to 31 days)
Health Screening	Low and High Plan - \$60 payable 1x per calendar year per family member enrolled	

*See certificate for full benefit details, including restrictions and maximum benefits.

Critical Illness

Critical Illness Insurance offers financial support if you or a loved one becomes seriously ill. It works alongside your medical coverage, paying a lump-sum amount upon diagnosis of a covered condition. The payment is yours to use however you like, whether for medical expenses, everyday costs or other needs.

Covered conditions include, but are not limited to: Cancer, Heart Attack, Stroke, Coronary Artery Bypass Graft, End State Renal Failure, Major Organ Transplant Benefit and Alzheimer's disease.

Eligible Coverage	Initial Benefit	Requirements
Employee	Available in \$10,000 increments, up to \$50,000	Coverage is assured provided the employee is actively at work
Spouse and Dependent Child(ren)	50% of the employee's benefit	Coverage is assured if the employee is actively at work and the spouse has no medical restrictions, as stated in the Certificate.
Health Screening	\$60 payable 1x per calendar year per family member enrolled	

*See certificate for full benefit details, including restrictions.

Cancer Insurance

Cancer insurance supplements your medical coverage, paying out regardless of what your medical plan covers. If you or a loved one is diagnosed with a covered cancer condition, you'll receive a lump-sum payment, dependent on the level of coverage chosen. If the cancer recurs, you'll receive another lump-sum payment equal to the initial benefit amount you selected.

Eligible Coverage	Initial Benefit	Requirements
Employee	Available in \$10,000 increments, up to \$50,000	Coverage is assured provided the employee is actively at work
Spouse and Dependent Child(ren)	50% of the employee's benefit	Coverage is assured if the employee is actively at work and the spouse has no medical restrictions, as stated in the Certificate.
Health Screening	\$60 payable 1x per calendar year per family member enrolled	

*See certificate for full benefit details, including restrictions.

Disability Insurance

The loss of income due to illness or disability may cause financial hardship for your family. Disability insurance programs work to replace a portion of your income when you're unable to work. The disability benefits you can enroll in allow you to continue paying your bills and meeting your financial obligations during this difficult time.

You can enroll in supplemental disability benefits that can be used alongside FMLA or before you're eligible for FMLA. FMLA is available to employees once they have reached 12 months of service.

Short-term Disability



Short-term disability insurance through UNUM is typically designed to help employees who are temporarily unable to work due to illness, injury, or other qualifying medical conditions.

Key Features of an STD plan:

1. **Income Replacement:** It covers up to 60% of your income, which helps you manage financially while you're unable to work.
2. **Benefit Limit:** The maximum benefit is capped at \$5,000 per month, so if you earn more than that, you'll still receive \$5,000, but no more.
3. **Portability:** One important feature of this policy is portability. If you ever leave the City of Springfield, you can keep the policy and continue coverage without interruption. This gives you flexibility and peace of mind, knowing you're covered even if you change jobs or move to a different location.

To enroll in a UNUM STD plan, contact Joe Ludtke at 217-321-3180.

Long-term Disability



Long-term disability (LTD) insurance through MetLife provides extended financial protection if you become seriously ill or injured and are unable to work for an extended period—usually beyond a few months.

Key Features of an LTD plan:

1. **Income Replacement:** It covers up to 60% of your gross monthly income, which helps you manage financially while you're unable to work.
2. **Benefit Limit:** The maximum benefit is capped at \$5,000 per month, so if you earn more than that, you'll still receive \$5,000, but no more.
3. **Portability:** One important feature of this policy is portability. If you ever leave the City of Springfield, you can keep the policy and continue coverage without interruption. This gives you flexibility and peace of mind, knowing you're covered even if you change jobs or move to a different location.



Dependent Care FSA

Optum

Dependent Care FSA is offered through Optum Financial. Much like the medical FSA, this allows you to set aside pre-tax dollars to pay for eligible dependent care expenses, such as childcare, eldercare or care for a dependent with special needs. This can help reduce your taxable income and save money on care expenses.

You can use the funds for services like:

- Daycare
- Before or After-school programs
- Summer day camps
- Adult dependent care

Eligibility:

- Full-time employee.
- Incur expenses to work or look for work.
- Not pay a dependent or child under 19.
- Have a filing status of single, qualifying widow(er), or married filing jointly/separately.
- Maintain a home with the qualifying child or dependent for over half the year.

Access to Funds:

Your Dependent Care funds are available year-round to cover eligible expenses. Funds will be available once deposited to your account.

Unlike the medical FSA, you may only receive reimbursement from your account equal to the amount you have deposited.

Contribution Limits

Each year, you decide how much money you want to contribute but there are limits on how much you can contribute.

- 2026 Contribution Limit: \$7,500

Use-It-or-Lose-It Rule and Carryover:

Dependent Care funds must be spent by the end of the plan year or the remaining funds will be forfeited.

[Optum.com/](https://www.optum.com/) is your place to:

- Access and manage your account.
- View your balance, check recent transactions and track eligible expenses.
- Submit receipts for eligible expense reimbursements.
- Set up direct deposit for faster processing.
- Access tools and resources: calculators, eligible expense lists and other helpful resources.
- Opt in for electronic communications



Parental / MAPA Leave

The City of Springfield offers up to 4 weeks of paid maternity, paternity, or adoption leave for eligible employees after the birth or adoption of a child. This leave is meant to support employees in bonding with their new child and is provided concurrently with Family and Medical Leave Act (FMLA) leave.

Eligibility:

- Must be an actively working regular employee (not a temporary employee or intern).
- Must meet one of the following criteria:
 - Given birth to a child.
 - Be the parent and/or legal guardian of the child born, adopted or placed.
 - Adopted a child under age 17 (excluding adoption of a spouse's child).

Key Details:

- Employees are required to submit their Certification Form before the 26th week of pregnancy.
 - This is required to ensure proper processing of the request.
- Submissions after the 26 week deadline will be denied.
- Leave must be taken in consecutive, full-day increments.
- Employees receive 100% of regular pay during leave.
- Maximum of 4 weeks of paid leave per birth or adoption event (no increase for multiple children).
- Both parents in the same department must stagger their leave to avoid operational disruptions.

Coordination with Other Policies:

- Paid leave runs concurrently with FMLA leave.
- After paid leave is exhausted, additional leave may be taken using accrued sick leave, vacation, or personal days.
- Benefits (healthcare, etc.) continue during the leave period.
- Holidays during leave are paid as holiday pay but don't extend the leave.

Application Process:

1. Submit "Certification of Pregnancy and Expected Due Date" form to HR during the first two trimesters (26 weeks)
2. Submit adoption documents to HR for adoptive parents.
3. Submit Family Medical Leave paperwork 30 days before the birth or adoption.

For full details, employees should consult the HR department or the Chapter 36 Leave policy.

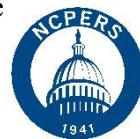
Financial / Retirement

- NCPERS
- Deferred Compensation



NCPERS Group Life Insurance

The National Conference on Public Employee Retirement Systems (NCPERS) offers a voluntary life insurance plan for IMRF members through Prudential Insurance.



Plan Features

- **Attractive Rates:** \$16/month premium allows for Coverage at lower group rates through NCPERS' purchasing power.
- **Rates Don't Increase With Age:** Coverage is based on your age and decreases as you age.
- **Easy Payment:** Pay through automatic payroll deductions.
- **24/7 Coverage:** You're covered on or off the job, 24 hours a day, 7 days a week.
- **Post-Retirement Coverage:** Continue coverage into retirement through premium deductions from your retirement check.
- **Student Loan Protection:** For members under 45, coverage includes up to \$50,000 in student loan reimbursement if you become totally disabled.
- **Total Disability Protection:** If you become totally disabled before age 60, your coverage may continue without contributions after nine months of disability.
- **Accelerated Death Benefits:** If terminally ill, you can access up to 50% of your death benefit in advance.
- **AD&D Coverage:** Additional benefits for accidents, including car accidents and tuition reimbursement for dependents.

Eligibility

- Active City of Springfield employees and IMRF members are eligible to enroll.
- Eligible dependents (spouse, domestic partner and unmarried children) are eligible with employee coverage.

[Ncpers.memberbenefits.com/imrf](https://ncpers.memberbenefits.com/imrf) is your place to:

- Learn about plan features, schedule of benefits and more.
- Member resources, FAQs, enrollment options.
- Submit claims, update beneficiaries.
- Watch videos, print online forms, and so much more.

Additional flyers and information are located on Employee Self Service. To enroll, please complete the enrollment and beneficiary form and return to Human Resources.

Deferred Compensation

The Deferred Compensation Plan is a voluntary retirement savings program designed to supplement your retirement income. City of Springfield employees can contribute a portion of their salary to a 457(b) plan on either a pre-tax or Roth basis. Contributions are made via payroll deduction and are directed to the chosen plan through one of the available vendors.

Pre-tax vs. Roth Contributions

- **Pre-tax Contributions:** Made before taxes, reducing your current taxable income. Taxes are paid when you withdraw the funds in retirement.
- **Roth Contributions:** Made after taxes, but qualifying distributions (after 5 years and age 59½, or if you become disabled or pass away) are tax-free.
- **Tax Benefits:** Pre-tax contributions grow tax-deferred, meaning taxes are paid upon withdrawal. Roth contributions grow tax-free, and qualifying withdrawals are also tax-free.

Contribution Limits for 2026

- \$23,500 for employees under 50
- \$31,000 for employees over 50
- \$34,750 for employees aged 60-63
- \$47,000 for employees enrolled in 'special catch-up' (available for those within 3 years of retirement)

Deferred Compensation Vendors

Please contact vendors directly for enrollment or questions regarding investments, withdrawals, loans, rollovers, transactions, etc.

Horace Mann

Katie Hageman
Hageman Family Insurance, LLC
✉ hageman@horacemann.com
☎ 217-788-5118 x4 Office

IPPFA

Jake Perkins
✉ jacobp@ippfabenefits.org
☎ 217-306-2041 Office

VALIC

David Jones, CFP
✉ david.jones@aig.com
☎ 217-714-2862 Cell

Equitable

Jim Gibbs
✉ james.gibbs@equitable.com
☎ 217-679-1737 x103 Office
☎ 217-899-1249 Cell

VOYA

Dale Blankenship
✉ dale.blankenship@lpl.com
Christen Owen
✉ christen.owen@lpl.com
Dan Stewart
✉ dan.stewart@lpl.com
☎ 217-525-9500

Wellbeing Benefits

- EAP
- FitClub
- Pet Insurance
- Credit Union



Employee Assistance Program

The City of Springfield offers an Employee Assistance Program (EAP) through Memorial Health to support employees and their families. This confidential, no-cost benefit is available to help address personal and work-related challenges, such as:

- **Mental Health:** Support for stress, anxiety, depression, or other emotional well-being concerns.
- **Substance Abuse:** Assistance for dealing with alcohol or drug-related issues.
- **Financial Concerns:** Guidance for budgeting, debt management, and financial planning.
- **Stress Management:** Resources to help cope with stress both at work and in personal life.

Key Features of the EAP:

- **Confidential Services:** All services provided through the EAP are completely confidential to ensure your privacy.
- **No Cost to You:** Employees and their families can use EAP services at no cost, regardless of whether you are enrolled in the City's health insurance plan.
- **Available to Employees and Their Families:** EAP services are available to all employees and their immediate family members.

Memorial Choice EAP Services include:

- Wellness Consultations
- Advance Care Planning
- Eldercare Assessment
- Financial Consultation
- Legal Consultation
- Educational Opportunities
- Behavioral Health Coaching
- Counseling Services

Counseling Services

Memorial Choice EAP provides up to 6 free counseling sessions per issue, per year for employees, spouses and their dependent children (26 and younger). If ongoing counseling or specialized treatment is recommended, your health insurance or other benefits may apply. In such cases, Memorial EAP will coordinate a referral to the most appropriate and cost-effective provider.

STEPS TO PARTICIPATE:

1. Call Memorial Choice EAP at 217-788-9345.
2. Following a brief intake, an appointment will be scheduled with the appropriate resources at a convenient time.
3. You will meet with a Memorial Choice EAP counselor or service line expert to discuss your concern in strict confidence.
4. Your counselor or service line expert will help resolve your concern and provide appropriate information for resolution or refer you to a specialist when appropriate.

Access resources online at memorial.health/eap.

City of Springfield employees have access to exclusive FitClub membership discounts – just for being a city employee! Even better, the ease of a monthly payment is completed through a payroll deduction. Choose from multiple membership types and levels.

Ways to enroll:

- Enroll online at Benefits Connect during Open Enrollment or New Hire Enrollment.
- After Open Enrollment ends, visit one of the three locations to view the facilities, meet with a Success Coach and sign your agreement in person.

FitClub locations:

- [FitClub North - 2701 E Sangamon Ave, Springfield, IL 62702](#) – (217) 788-8250
- [FitClub West - 2811 W Lawrence Ave, Springfield, IL 62704](#) – (217) 787-1111
- [FitClub South - 3631 South 6th Street, Springfield IL 62703](#) – (217) 787-8348

**Facilities are open 24/7, but walk-in hours for any employees who would like to enroll in person or to fill out the payroll deduction form are: Mon - Fri 8am-6pm and (FitClub South only) Sat 10am-3pm*

Additional Information:

- Success Coaches are available to assist with setting up your membership, answer questions, assist with the payroll deduction form and receive an orientation to the club.
- Enrollment at any location is valid for all locations, choose what is most convenient for you.
- You are required to sign the payroll deduction form at the club. Emailed copies will not be accepted.
- Personal payment information will be collected by FitClub for in-club purchases throughout your membership.
- Details and Terms and Conditions are located within the online enrollment process as well as at FitClub.
- Exciting Challenges will be held throughout the year.

Membership Options

	Basic Access	Full Access
Features	• 24/7 secured access to all (3) facilities • All equipment and training zones • Locker rooms + saunas • Complimentary fitness consultation + InBody • FitClub Members App • FitClub Perks Rewards Program	Everything in Basic, plus: • 100+ weekly Group Exercise classes (Zumba, Yoga, Pilates, BodyPump, CycleFit & more) • Jacuzzis, lap pools and therapy pools • 40+ water exercise classes each week • Private lap lane reservations • Child Care at all three locations • Les Mills on Demand (500+ workouts)
<u>Monthly Costs</u> • Employee Only • Employee +1 • Family	\$12.50 / pay period \$22.50 / pay period \$30.00 / pay period	\$15.50 / pay period \$27.50 / pay period \$35.00 / pay period

**Plans are a 12-month agreement with auto-renewal*

Pet Insurance

MetLife Pet Insurance

MetLife Pet Insurance is simple, flexible, and designed to help you care for your pets. This benefit that helps cover the cost of veterinary care for your pets and can assist with medical care, emergencies, surgeries, illnesses and accidents.



Key Features:

- Comprehensive Coverage: Covers accidents, illnesses, wellness care, emergency care, surgeries, and diagnostic tests.
- Customizable Plans: Choose your deductible, reimbursement percentage (50%-90%), and coverage limits.
- Affordable Premiums: Plans tailored to your pet's age, breed, and coverage level.
- Immediate Accident Coverage: No waiting period for accidents.
- Veterinary Choice: Visit any licensed vet.
- Easy Claims: Submit claims online or via the app, with reimbursement in about five days.

What's Covered?

- Accidental Injuries
- Illnesses
- Exam Fees
- Surgeries
- Medications
- Ultrasounds
- Chronic Conditions
- Hospital Stays
- X-rays
- Diagnostic Tests
- Hereditary Conditions
- Congenital Conditions
- Holistic Care
- And much more!

What's not Covered?

- Pre-existing conditions are typically not covered, but MetLife will cover those previously covered by another pet insurance provider—to learn more about what's not covered, visit metlifepetinsurance.com/coverage-exclusions.

What will it cost?

Each pet's premium will be based on your pet's age, breed and location, as well as the selected coverage amount. City of Springfield employees are automatically eligible for a 10% employer group discount.

How do I pay for coverage?

Premiums will be paid directly to MetLife and not completed by a payroll deduction.

Get a quote or enroll today.
metlife.com/getpetquote

Call 1-800-GET-MET8 (1-800-438-6388)
Scan the QR code



**Protect your
pets —
and your
finances.**



Employee Credit Union

SCECU has something for everyone!



Retirees

If you're retired and receive IMRF, Social Security, or Police Pension, we can receive your direct deposit. Visit us to set up a partial or full deposit!

Custodial Accounts (Minors)

We offer accounts for your minor children or grandchildren, which can receive direct deposits from payroll or pensions.

Employees

- Payroll Deductions: For savings and loan payments.
- Direct Deposits: For your checking (share draft) accounts.
- Inter-Office Mail: Convenient services for CWLP employees.

Springfield City Employees Credit Union offers:

- Free checking
- Online Banking
- Debit/ ATM cards
- Bill Pay
- Savings Accounts
- Property Tax Account
- Christmas Club Account
- Visa Credit Card
- Visa Gift Card
- Vehicle/Signature Loans

Who Can Join?

Membership is open to all City of Springfield employees, including those from utility, water, light, power, and Springfield Housing Authority, plus their immediate family (spouse, parents, children, siblings, grandparents, and grandchildren).

Payroll Deduction – Save Time and Avoid Late Fees

Set up payroll deduction for your loan payments or direct deposits and never worry about late fees again!

- **Automatic Payments:** Loans paid directly from your paycheck.
- **No Late Fees:** Always on time, every time.
- **Convenience:** Save time and avoid the hassle of manual payments.

Contact Information

300 S. 7th St, Room B4

Springfield, IL 62701

Phone: (217) 789-2346

Fax: (217) 789-2190

Hours: M – F: 8am – 4:30pm

Email: creditunion@scecu.org

Compliance Notices

- 2026 Annual Notices



2026 Annual Notices

HIPAA Special Enrollment Rights Notice

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Luminare Health Benefits.

Newborns' and Mothers' Health Protection Act (NHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits health benefit plans from discriminating on the basis of genetic information in regards to eligibility, premiums, and contributions. This generally also means that private employers with more than 15 employees, its health plan, or "business associate" of the employer, cannot collect or use genetic information (including family medical history information). The one exemption would be that a minimum amount of genetic testing results may be used to make a determination regarding a claim.

You should know that GINA is treated as protected health information (PHI) under HIPAA. The plan must provide that an employer cannot request or require that you reveal whether or not you have had genetic testing; nor can your employer require you to participate in a genetic test. An employer cannot use any genetic information to set contribution rates or premiums.

HIPAA Notice of Availability of Notice of Privacy Practices

The City of Springfield's Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact City of Springfield Benefits - Office of Human Resources.

Model General Notice of COBRA Continuation Coverage Rights

****Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;

- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Springfield Benefits - Office of Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Contact City of Springfield Benefits - Office of Human Resources for additional information.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the

Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

City of Springfield Benefits - Office of Human Resources

humanresources@springfield.il.us

217-798-2446

USERRA Notice

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services. In addition to the rights that you have under COBRA, you (the employee) are entitled under USERRA to continue the coverage that you (and your covered dependents, if any) had under the City Of Springfield Plan.

You Have Rights Under Both COBRA and USERRA. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the attached COBRA Election Notice also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Definitions

"Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

"Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System.

Duration of USERRA Coverage

General Rule: 24-Month Maximum. When a covered employee takes a leave for service in the uniformed services, USERRA coverage for the employee (and covered dependents for whom coverage is elected) can continue until up to 24 months from the date on which the employee's leave for uniformed service began. However, USERRA coverage will end earlier if one of the following events takes place:

A premium payment is not made within the required time;

You fail to return to work or to apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services;

You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

USERRA and Health FSAs

USERRA's continuation coverage requirements for health plans apply to health FSAs. USERRA has no special rules for health FSAs. For example, the limited COBRA obligation for certain health FSAs (as described in the attached COBRA Election Notice) does not apply under USERRA—under USERRA, the right to continuation coverage generally lasts for up to 24 months (unless one of the events described above takes place).

COBRA and USERRA Coverage Are Concurrent

This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described in the attached COBRA Election Notice)., USERRA coverage can continue for up to 24 months.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage pursuant to USERRA, you will be required to pay 102% of the full premium for the cover-age elected (the same rate as COBRA), at the times and using the procedures specified in the attached COBRA Election Notice. However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

For the full USERRA notice of rights, which includes details regarding periods of uniformed service as it relates to report-to-work requirements, please contact City of Springfield Benefits—Office of Human Resources.

Medicare Part D Creditable Coverage Notice

Important Notice from City of Springfield About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Springfield and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in City of Springfield’s coverage as an active employee, please note that your City of Springfield coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in [Insert Name of Entity] coverage as a former employee.

You may also choose to drop your City of Springfield coverage. If you do decide to join a Medicare drug plan and drop your current City of Springfield coverage, be aware that you and your dependents may not be able to get this coverage back.

If you decide to join a Medicare drug plan while enrolled in City of Springfield’s coverage as an active employee, please note that Medicare will generally be the primary payer for your prescription drug benefits and your City of Springfield coverage will pay secondary. As a result, the value of your City of Springfield prescription drug benefits may be significantly reduced.

You may also choose to drop your City of Springfield coverage. If you do decide to join a Medicare drug plan and drop your current City of Springfield coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Springfield and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base

beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Springfield changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Name of Entity/Sender: City of Springfield

Contact--Position/Office: City of Springfield Benefits - Office of Human Resources

Address: 800 East Monroe, Springfield, IL 62701

Phone Number: 217-789-2446

HIPAA Notice of Privacy Practices

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

City of Springfield ("City of Springfield") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of City of Springfield, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by City of Springfield, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the City of Springfield's HIPAA Privacy Officer or:

City of Springfield Benefits - Office of Human Resources Attention: HIPPA Privacy Officer
800 East Monroe Springfield, IL 62701

Effective Date

This notice as revised is effective March, 1, 2026.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
 - provide you with certain rights with respect to your protected health information;
 - provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information;
- and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet at [insert intranet address]. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the

Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period City of Springfield has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Your Rights Continued

Right to Request Restrictions You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

You have the following rights with respect to your protected health information:

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	NEBRASKA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan’s copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **“balance billing.”** This amount is likely more than in-network costs for the same service and might not count toward your plan’s deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan’s in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care.

You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

- » Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

- » Cover emergency services by out-of-network providers.

- » Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- » Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights: Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to [learn more about protections from surprise medical bills](#) and for [contact information for the state department of insurance or other similar agency/resource in your state](#) to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.