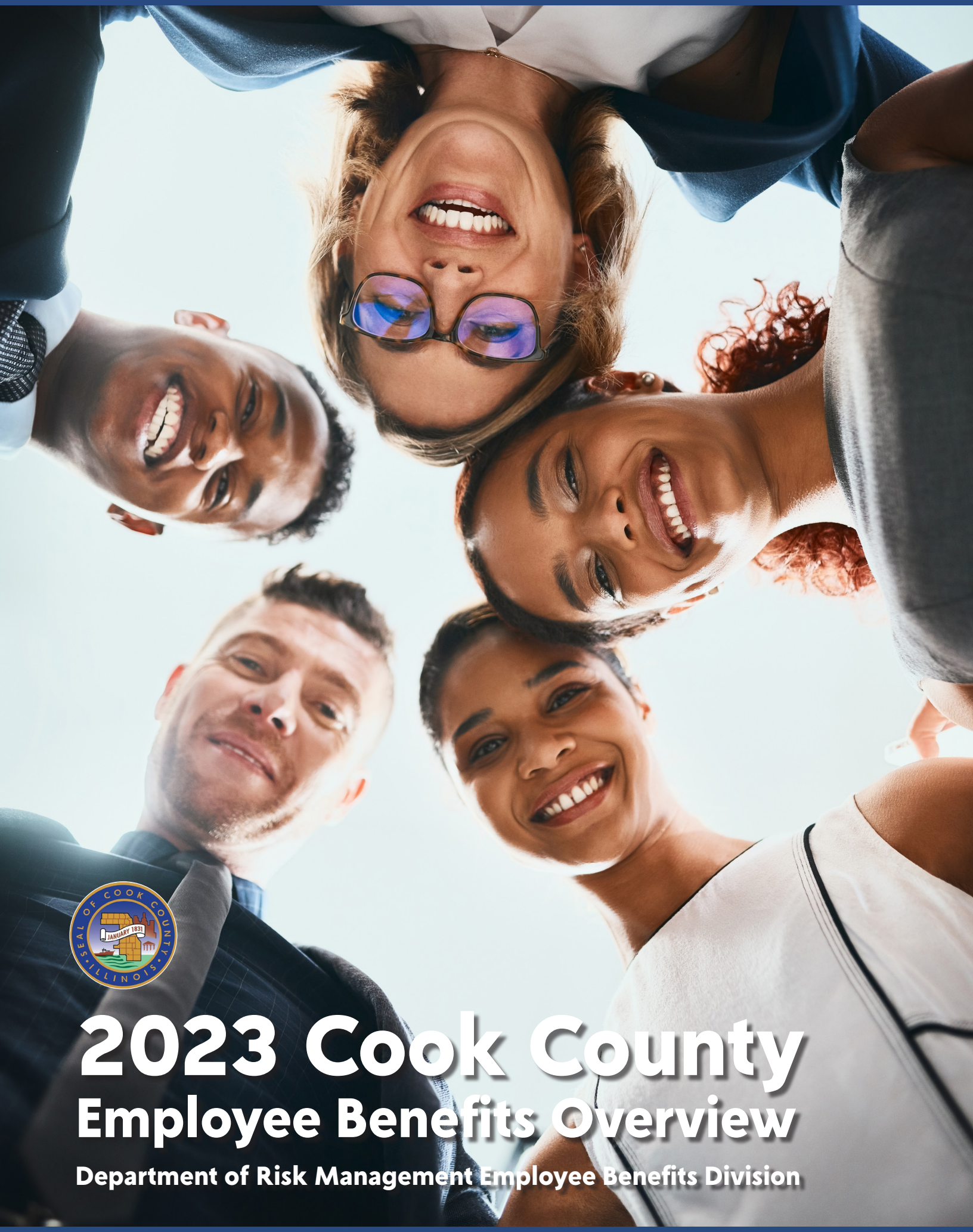

2023 Cook County
Employee Benefits Overview

Department of Risk Management Employee Benefits Division

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WELCOME

Employees have unique needs when it comes to benefits, and Cook County offers a comprehensive program so you can choose what is important to protect the health and well-being of you and your family.[1]

Cook County offers a competitive employee benefits package and remains committed to offering benefits at the most affordable cost to employees. The County provides some benefits at no cost to you, some you pay for, and other benefit costs are shared between Cook County and you.

The information in this guide highlights Cook County's Employee Benefits and well-being programs, as well as important information about your rights and responsibilities under the plans. Please take the time to review this guide carefully. You may only make changes to your benefit elections during the annual Open Enrollment period or if you experience a Qualifying Life Event such as a marriage, divorce or the birth/adoption of a child.

This guide, the Employee Benefits website **www.cookcountyrisk.com**, and the Employee Benefits team in the Department of Risk Management are your resources to educate yourself and choose the options best for you.

Contact Risk Management by phone at 312-603-6385 or email at **risk.mgmt@cookcountyil.gov** if you have questions or need additional assistance.

[1]Every effort is made to ensure the information in this guide is accurate. In the event of a discrepancy between the information in this guide and the official Plan Certificates, the official Plan Certificates govern.

KNOW YOUR BENEFITS

Review your benefits annually in Employee Self Service (ESS). Medical, dental and vision enrollments are in effect unless you make changes during the annual Open Enrollment period each year. You must enroll in health care and dependent day care flexible spending accounts (FSAs) each year to participate–elections do not carry over from one year to the next.

Check ESS to make sure your personal information is correct for you and your dependents.

- ❑ Name
- ❑ Date of Birth
- ❑ Social Security Number
- ❑ Home Address

Check ESS to make sure your benefits enrollment is as expected.

- ❑ Medical Insurance
- ❑ Dental Insurance
- ❑ Vision Insurance
- ❑ Health Care FSA
- ❑ Dependent Day Care FSA
- ❑ Group Basic Term Life

Check the Voluntary Benefits webpage on **www.cookcountyvoluntarybenefits.com** to make sure your enrollment is as expected.

- ❑ Group Accident Insurance
- ❑ Group Critical Illness Insurance
- ❑ Group Hospital Indemnity Insurance
- ❑ Short-Term Disability Insurance
- ❑ Universal Life Insurance
- ❑ Identity Theft Protection
- ❑ Legal Service Plan

Check the benefits plan site to manage your Group Supplemental Life and Commuter Benefits.

- ❑ Group Supplemental Life (**www.metlife.com/mybenefits**)
- ❑ Commuter Benefits (**www.optumfinancial.com**)

WHO IS ELIGIBLE TO ENROLL

You are eligible to participate in Cook County's group benefit plans if you are:

- An employee working at least 30 hours per week on a regular, year-round basis
- Eligible for participation in Cook County's group benefit plans pursuant to the Board of Commissioners' Budget Resolution, a collective bargaining agreement or an employment agreement

Dependent benefits are extended to spouse, domestic partners and civil union partners. If both the employee and spouse or partner are Cook County employees, all family members must be covered under one enrollment. Children up to age 26 are eligible for health benefits coverage as dependents. Military veterans may be covered up to the age of 30.

Dependent Verification

When you enroll dependents in the County's benefits, you will be asked to provide information about each of your eligible dependents, such as name, date of birth, Social Security number (SSN), and gender. You will also be required to submit documentation of the dependent's relationship to you. Requested proof includes a government-issued birth certificate or marriage certificate.

You are required to provide the SSN of each of your dependents. However, if your dependent does not have a SSN when you enroll, you should continue the enrollment and return to ESS once you have received the SSN and enter the information.

By enrolling your dependents, you are affirming that each dependent you are enrolling meets all eligibility requirements. If at any time your covered dependent no longer meets eligibility requirements, you agree to promptly remove that dependent from your coverage.

Coverage Tiers

If you choose to participate in a medical, dental and/or vision plan, you also must choose a Coverage Tier. The County offers four tiers of coverage in the medical plan:

- **Employee Only:** Coverage for you only
- **Employee Plus Spouse/Partner:** Coverage for you and your spouse/partner only
- **Employee Plus Child(ren):** Coverage for you and your eligible child(ren), including the eligible child(ren) of your spouse/partner
- **Employee Plus Family:** Coverage for you, your spouse/partner, your eligible child(ren) and your spouse's/partner's eligible child(ren)

Tiers for the dental and vision plans are Employee Only, Employee +1, and Family.

You can choose a different coverage tier for medical, dental and vision. For example, you might enroll in "Employee Only" coverage for medical if your spouse/partner has medical coverage from his or her employer and "Employee Plus Spouse/Partner" for dental coverage if your spouse's/partner's employer does not offer dental coverage. If enrolled, you and your dependents must elect the same plan.

WHEN YOU CAN ENROLL

You can enroll in County coverage within 31 days of the date you first become eligible, during the annual Open Enrollment period or within 31 days of a Qualifying Life Event (QLE). Benefits are effective the first day of the month following the date you became benefits eligible, except for Group Term Life Insurance, which is effective your first day of employment.

New Hire or Newly Eligible for Benefits

As a newly hired benefits-eligible employee, or if you are newly eligible for benefits, you have 31 days from your date of eligibility to enroll in the County's benefit plans. Enrollment is not mandatory. The monetary penalty for not having health coverage under the Affordable Care Act is no longer applicable.

Enrollment in Group Term Basic Life Insurance is automatic. You are not required to enroll in this benefit. If you wish to be enrolled in other benefits, you are required to act. You are required to enroll in the coverages listed below because enrollment is not automatic, and you will not be defaulted into any plan. All coverage continues each year unless you make changes; however, you must enroll each year to participate in the Health Care Flexible Spending Account (HCFSA) and Dependent Day Care Flexible Spending Account (DCAP).

YOU MUST ENROLL WITHIN 31 DAYS* TO HAVE COVERAGE:	YOU MAY ENROLL AT ANY TIME THROUGHOUT THE YEAR:
• Medical coverage • Dental coverage • Vision coverage • Group Supplemental Life • Health Care and Dependent Day Care Spending Accounts* • Voluntary Benefits	• Commuter Benefits • Deferred Compensation

You must enroll in HCFSA and DCAP each year to have coverage.

HOW TO ENROLL IN BENEFITS DURING ANNUAL OPEN ENROLLMENT

Choose your benefits carefully and understand all your benefit options so you can make an informed decision for the upcoming year.

> If you want to enroll in County coverage; drop County coverage; change to a different medical, dental or vision option; enroll in a flexible spending account; or change your coverage tier, for example, from single to family or vice versa, you must do so during the annual Open Enrollment period. **All changes are binding from December 1 through November 30**, unless you experience a QLE. If you experience a QLE, you may add, change or cancel coverage within 31 days of the event. Benefit changes must be made within 31 days of the QLE. *See the Qualifying Life Events section for more information.*

Medical, Dental and/or Vision Coverage

If you previously enrolled in coverage and do not change benefit elections during a subsequent annual Open Enrollment period, you will be assigned the same coverage for the following year. Plan enrollment changes are effective December 1.

Health Care Flexible Spending Account (HCFSA) and/or Dependent Day Care Spending Account (DCAP)

FSA enrollments do not carry over so you must re-enroll each year to participate. FSA elections are effective January 1.

Voluntary Benefit Plans

You can enroll each year during annual Open Enrollment (or as a new hire) or within 31 days of a QLE.

Once you are enrolled, your participation will continue as long as you maintain eligibility requirements unless you elect to drop coverage during a subsequent annual Open Enrollment period.

After You Enroll or Waive Confirmation of Enrollment

Once you submit your enrollment elections in ESS, you will be able to view your benefits elections. Review your benefits elections carefully to confirm they are accurate. You can review your elections or make changes to your benefits until the deadline. All enrollments are final as of 11:59 p.m. CST on October 31. A confirmation of your enrollment can be printed from ESS.

CHANGE YOUR BENEFITS – PERMITTED DURING QUALIFYING LIFE EVENTS

Open Enrollment is the annual period available to make changes to your benefits. A Qualifying Life Event (QLE) is required for you to request changes to your benefits outside of the Open Enrollment period. You can enroll, add or remove dependents; change plans; or enroll in/make changes to a flexible spending account within 31 days of any of the following events:

- Employment
- Marriage, establishment of a partnership (with government-issued domestic partner certificate or civil union certificate)
- Birth, adoption, or obtaining legal guardianship of a child
- Loss of other coverage for you or your dependent(s) for reasons such as legal separation, divorce, death, termination of employment or moving outside of the service area
- A change in employment status significantly impacting the employee contribution rate

Changes must be completed through Employee Self Service (ESS) within 31 days of the QLE. Appropriate dependent documentation must also be uploaded within 31 days. Government-issued newborn birth certificates must be uploaded within 45 days.

Please note: QLE additions are effective on the event date (e.g., due to marriage, birth). A QLE that terminates participation, such as waived coverage or the removal of a dependent from coverage (e.g., a divorce, death of a dependent, or aging out), is effective the last day of the month in which the event occurs.

Enrollments not completed within the designated time frame will not be accepted. The next opportunity to enroll will be the following annual Open Enrollment period or within days of another QLE.

If you are not currently enrolled and your QLE does not include a dependent change, please send an email to **risk.mgmt@cookcountyil.gov** to set up your eligibility to enroll in ESS. Enrollments entered more than 31 days after the QLE will not be processed.

Dependent children who reach the age of 26 (30 for military veterans) are automatically terminated from benefit coverage on the last day of the month of the 26th birthday. Special rules apply to disabled dependents.

BE AWARE! THERE'S ONLY A 31-DAY WINDOW TO MAKE CHANGES!

You must make changes to your benefits within 31 days of your life event, or you will have to wait until the next Open Enrollment period.

Coverage begins on the date of the event.

ENROLLMENT PROCEDURE

STEP 1: Log in to Employee Self Service (ESS).
To access ESS from within the County's network, click on the Oracle EBS icon on your desktop or use **www.ccgprod.ccounty.com** and then click on the applicable button.

You may also log in to ESS from home at: **www.ccgprod.cookcountyil.gov**
For assistance with logging into ESS, contact your agency's technology desk.

STEP 2: Complete your enrollment within 31 days of a QLE or during annual Open Enrollment using ESS.

Your dependents will not have medical, vision, or dental coverage unless you **SUBMIT THE REQUIRED DOCUMENTATION BY THE DEADLINE**.

STEP 3: Upload copies of documents to prove they are your legal dependents.

STEP 4: Print and retain your confirmation statement for your records. This is the only confirmation of your enrollment.

STEP 5: Monitor your Cook County email. Risk Management will contact you via email to notify you of any problems with your dependent enrollment or documentation.

Note: You are encouraged to submit documents right away to avoid delays in processing.

REQUIRED DOCUMENTS FOR DEPENDENTS

If you include dependents in your Cook County coverage, you must submit proof of eligibility for each dependent. Required documents must be scanned and uploaded through ESS.

DEPENDENT BEING ENROLLED	DOCUMENT(S) REQUIRED
Spouse	Government-issued marriage certificate
Child (0-25yrs.)	Government-issued birth certificate with employee's name listed as parent
Adult Military Dependent Child (Age 26-30) Illinois Resident	Government-issued certified birth certificate, proof of Illinois residency, DD Form 214 indicating discharge other than dishonorable discharge
Adopted Child	**At time of placement:** A copy of legal adoption documentation showing placement in employee's home prior to adoption, or one of the following: • Interim order with judge's signature and the circuit court file stamp • Petition for adoption with the circuit court file stamp • Pre-adoptive notarized placement agreement establishing the employee's obligation to provide support for the child in anticipation of adoption • Placement papers signed by the court **Within 31 days of finalized adoption:** • Final order of adoption issued through court, or • Final adoption certificate issued through court
Legal Guardianship of Dependent (Court Appointed)	Certified guardianship documents signed by judge and stamped by circuit court placing the child in the home (date of placement)
Civil Union Partner	Government-issued civil union certificate
Domestic Partner	Government-issued domestic partnership certificate

What Happens If I Do Not Enroll?
If you do not enroll within 31 days following your hire date or the date you become eligible for benefits, you will not have medical, dental and/or vision coverage through the County. Additionally, you will not be able to contribute to flexible spending accounts. You will have to wait until the next Open Enrollment or until you experience a QLE.

EFFECTIVE DATE OF BENEFITS COVERAGE

New Hire: 1st day of the month following date of hire

Qualifying Life Event:

- Event date when adding coverage (e.g., due to marriage, birth)
- Last day of the month in which the event date occurs when removing coverage or dependents from coverage

Open Enrollment: December 1 (FSA OE changes begin January 1)

COORDINATION WITH OTHER COVERAGE

If you are eligible for benefits coverage elsewhere, for example, through a spouse's/partner's or other employer's plan, you should compare the County's coverage and costs to the other coverage. You may decide to enroll in some plans offered through the County and some from the other source.

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans, but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called "coordination of benefits."

DUAL COVERAGE

Dual coverage is prohibited on all County benefit plans for employees and dependents if both individuals work for Cook County in a benefit-eligible position. If a dual-coverage enrollment is made, the Employee Benefits Division will update the enrollment based on a pre-defined order of benefits determination so that each individual is only enrolled in coverage under one record. Both parties involved in the dual-coverage enrollment will be notified of the change.

COST AND FUNDING

Contributing to Your Plans

You and the County share the cost for medical coverage, with the County paying the majority of the costs as shown in the chart below.

Cook County pays the full cost...

- Basic Life Insurance
- Dental Insurance
- Vision Insurance

You pay the full cost...

- Commuter Benefits
- Deferred Compensation
- Flexible Spending Accounts
- Supplemental Life Insurance
- Voluntary Benefits

You and Cook County share the cost...

- Medical (including prescription drug)

For full time employees, your cost is based on the plan and coverage tier you choose and your annual salary (based on 1.0 FTE) as shown in the chart on the following page:

CALCULATING YOUR COVERAGE

This chart shows your cost as a percentage of pre-tax standard salary based on plan selected and family members you elect to cover.

	HMO	PPO
Employee Only	1.75%	2.75%
Employee + Spouse	2.50%	3.50%
Employee + Children	2.25%	3.25%
Employee + Family	3.00%	4.00%

Employees working less than 30 hours/week may contribute at a different rate.

Employees on an approved leave of absence remain responsible for their regular payroll contributions when billed.

Employees on a personal leave of absence are responsible for paying the full County cost for continued coverage.

LEAVE OF ABSENCE

Part-time Employees and Employees on a Personal Leave of Absence

Part-time employees and employees on a Personal Leave of Absence (PLOA) are required to notify Risk Management in writing that they wish to enroll in benefits or continue coverage within 31 days of the status change. Once the enrollment or PLOA continuation is processed, Risk Management will issue and mail a monthly invoice to the employee for payment of insurance. These employees are required to pay the full County cost of coverage.

Health Insurance Statements

The Department of Revenue issues and mails statements to employees for the payment of health insurance deductions when they are not able to be deducted from a regular paycheck or if no paycheck is issued.

Employees on an unpaid leave status must pay their account balances in full or return to work by the date provided or coverage will be terminated. Employees back at work whose balances are not paid in full will have their accounts turned over to a collection agency.

TERMINATION / COBRA

Coverage for employee health benefits ends on the last day of the month following the employment termination date.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and/or their dependents to continue certain insurance benefits after termination of employment or when a dependent's status changes, resulting in loss of coverage. Medical, dental and vision plans can be continued for up to 18 months under COBRA, or longer in certain circumstances.

Once the COBRA enrollment is processed, Risk Management will issue and mail a monthly invoice to the employee for the full County cost plus an administrative fee. Employees have 60 days to apply for coverage retroactive to the benefits termination date.

BlueCross BlueShield of Illinois

MEDICAL PLAN

Cook County offers two medical plan options to choose from when selecting coverage for you and your family. Each medical plan includes a prescription drug benefit. Your medical plan choices are HMO or PPO.

HMO	PPO
No deductibles or coinsurance. Employees are responsible for copays.	There are deductibles, coinsurance and copays.
Must select a primary care physician. There is no out-of-network coverage except in an emergency.	Covers in-network and out-of-network doctors. Selection of a primary care physician is strongly encouraged but not required. Offers financial savings for services obtained in the Domestic tier of coverage.
Requires a referral from your primary care physician to see a specialist.	Can visit a specialist without a referral. Pre-certification is required for certain services.

www.bcbsil.com/cookcounty
BlueAdvantage HMO
Group #B03351
1-800-892-2803

Blue Cross Blue Shield PPO
Group #291116
1-800-960-8809

SUMMARY OF HEALTH BENEFITS

Feature	HMO Plan	Cook County Domestic Tier	PPO Plan In-Network	PPO Plan Out-of-Network
Annual deductible	$0	$350 individual $700 family		$700 individual $1,400 family
Out-of-Pocket (OOP) maximum	$1,600 individual $3,200 family	$2,000 individual $4,000 family		$4,000 individual $8,000 family
NOTE: You are responsible for the full cost of any charges that exceed the Schedule of Maximum Allowances (SMA), sometimes referred to as "R&C" or "reasonable and customary" amount.				

Benefits	HMO Plan	Cook County Domestic Tier	PPO Plan In-Network	PPO Plan Out-of-Network
Primary Care				
Primary care visit to treat an injury or illness	$15 copay/visit	$25 copay+10% coinsurance/visit		40% coinsurance/visit
Specialist visit	$20 copay/visit	$35 copay+10% coinsurance/visit		40% coinsurance/visit
Other practitioner office visit	$15 copay/visit	$25 copay+10% coinsurance/visit		40% coinsurance/visit
Preventative care/screening/ immunization	$0 copay/visit	$0		$0
Outpatient Services				
Diagnostic test (x-ray, blood work) and imaging (CT/PET scans, MRIs)	$0	0% coinsurance	10% coinsurance	40% of the maximum allowance
Facility fee (e.g., ambulatory surgery center)	$100 copay/visit	0% coinsurance	10% coinsurance	40% of the maximum allowance
Physician/surgeon fees	$0	10% coinsurance		40% coinsurance
Maternity prenatal/postnatal care	$15 copay/visit First prenatal visit only	$25 copay/visit+10% coinsurance First prenatal visit only		40% coinsurance
Mental/behavioral health outpatient services	$15 copy/visit	$25 copay/visit+10% coinsurance		40% coinsurance
Substance use disorder outpatient services	$15 copy/visit	$25 copay/visit+10% coinsurance		40% coinsurance
Emergency Care				
Emergency room services	$100	$100		
Emergency medical transportation	$0 Ground transportation only	10% coinsurance		
Urgent care	$15 copay/visit Must be affiliated with chosen medical group or referral required	$25 copay/visit+10% coinsurance		$25 copay+40% coinsurance
Inpatient Benefits				
Facility fee (e.g., hospital room)	$100 copay/visit	0% coinsurance	10% coinsurance	40% coinsurance
Physician/surgeon fee	$0	10% coinsurance		40% coinsurance
Mental/behavioral health inpatient services	$100 copay/admission	0% coinsurance	10% coinsurance	40% coinsurance
Substance use disorder inpatient services	$100 copay/admission	0% coinsurance	10% coinsurance	40% coinsurance
Delivery and all maternity inpatient services	$100 copay/admission	0% coinsurance	10% coinsurance	40% coinsurance
Extended Care				
Home health care	$0	10% coinsurance		40% coinsurance
Skilled nursing care	$100 copay/admission	10% coinsurance		40% coinsurance
Hospice service	$0	10% coinsurance		40% coinsurance
NOTE: Effective 12/1/21, The County PPO plan will incorporate a Cook County Health tier ("Domestic Tier") wherein covered members will have lower out-of-pocket costs when choosing to access health care within CCH faciities. Facility charges will be 0% after the annual plan deductible is met. Hospital-based facility services not obtained at CCH will be paid based on their network status (in or out of network rate.)				

PRESCRIPTION DRUG PROGRAM

When you enroll in a medical plan, you automatically receive prescription drug coverage through CVS Health. Prescriptions can be purchased through your local pharmacy or mail order. CVS Health pharmacy is included in all Target stores that offer pharmacy services. Prescription copays range from $15 to $100 depending on your prescription.

You will save money by purchasing generic drugs rather than brand-name drugs.

	30-DAY SUPPLY AT RETAIL	90-DAY SUPPLY*
Generic	$15	$30
Formulary brand on the drug list	$30	$60
Non-formulary brand not on the drug list	$50	$100

Maintenance Choice Program

The Maintenance Choice Program is mandatory. After two fills, all maintenance medications must be filled in a 90-day supply through mail order or at a CVS Pharmacy.

*If you choose to buy a formulary brand (on the drug list) or non-formulary brand (not on the drug list) when a generic substitute is available, you will pay the generic copay, plus the difference in cost between the generic and the full retail formulary brand or non-formulary brand drug cost.

You must ask your doctor to write a 90-day supply prescription and get it filled at your CVS Pharmacy.

Generic Step Therapy Program

The Generic Step Therapy Program requires members to use up to two generic alternatives in certain drug classes before a brand will be covered.

www.caremark.com
1-866-409-8522

DENTAL PROGRAM

Dental coverage is provided to employees and enrolled dependents at no charge. Regular visits to the dentist can do more than just brighten your smile; they can also be important to your overall health.

County employees have a choice of two dental plans:

- Guardian Dental HMO provides access to services performed at participating dental HMO practices
- Guardian Dental PPO allows you to seek dental care from dentists who are in or out of the PPO network, with greater coverage in-network

www.guardiananytime.com/cookcounty
Dental HMO: 1-866-494-4542
Dental PPO: 1-866-302-4542

See the Summary of Dental Plans on page 16

SUMMARY OF DENTAL PLANS

Item/Procedure	Dental HMO Copayment (Member Pays)	Dental PPO	
		In-Network	Out-of-Network
Benefit Period Maximum	None	$1,500	
Deductible	None	$25 per Individual $100 per Family (4 individual maximums) Deductible does not apply to preventive and orthodontic services	$50 per Individual $200 per Family (4 individual maximums) Deductible does not apply to preventive and orthodontic services
Preventative			
Dental Exams (2 exams per benefit period)	$0	100% of the maximum allowance	80% of the maximum allowance
Profylaxis (2 exams per benefit period)	$0	100% of the maximum allowance	80% of the maximum allowance
Fluoride Treatment (2 exams per benefit period)	Once every 24 months	100% of the maximum allowance	80% of the maximum allowance
Primary Services			
Dental X-Rays	$0	80% of the maximum allowance	60% of the maximum allowance
Space Maintainers (eligible members up to age 19)	$63-$96	80% of the maximum allowance	60% of the maximum allowance
Restorative			
Amalgams and Anterior Resins	$17-$44	80% of the maximum allowance	60% of the maximum allowance
Posterior Resins	$53-$105	80% of the maximum allowance	60% of the maximum allowance
Crowns and Fixed Bridges	$256-$300 per unit	50% of the maximum allowance	50% of the maximum allowance
Emergency Services			
Palliative Emergency Treatment	$0	80% of the maximum allowance	80% of the maximum allowance
Endodontics			
Root Canal Therapy	$109-$162	80% of the maximum allowance	60% of the maximum allowance
Periodontics			
Scaling and Root Planing	$37/quadrant	80% of the maximum allowance	60% of the maximum allowance
Gingivectomy	$111/quadrant	80% of the maximum allowance	60% of the maximum allowance
Osseous Surgery	$206/quadrant	80% of the maximum allowance	60% of the maximum allowance
Oral Surgery			
Routine Extractions	$18-$20	80% of the maximum allowance	60% of the maximum allowance
Removal of Impacted Teeth (soft tissue and partial bone)	$$50-$65	80% of the maximum allowance	60% of the maximum allowance
Prosthetics			
Full or Partial Dentures	$383-$396	50% of the maximum allowance	50% of the maximum allowance
Denture Reline	$40-$72	50% of the maximum allowance	50% of the maximum allowance
Endosseous Implants	Not covered	50% of the maximum allowance	50% of the maximum allowance
Orthodontics			
Adults (19 or older)	Not covered	50% of the maximum allowance	
Dependent Children (up to age 19)	$3,233-$3,356 not including x-rays or orthodontic records	50% of the maximum allowance	
Lifetime Maximum	One full course of treatment for dependent children under age 19	$1,250	

DavisVision™

VISION PROGRAM

Vision coverage is provided at no charge to employees and enrolled dependents. Eye exams are an important part of your overall health.

The vision plan is administered by Davis Vision and covers routine eye exams, as well as prescription eyeglasses and contact lenses. The amount you pay for your vision care depends on the type of services or eyewear you choose.

Coverage is only available if you use an in-network provider. To locate a Davis Vision provider, visit:

www.davisvision.com
1-800-381-6420

See the Summary of Vision Plans on page 18

VISION PLAN SUMMARY

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with dilation as necessary	$0 copay	N/A
Frames	$0 copay; $100 allowance, plus 20% discount on balance	N/A
	Benefits specific to Davis Vision, $150 allowance at Visionworks, or Davis Vision "Exclusive Collection" covered in full	
Lens Options (paid by the member in addition to the price of the lenses)		
Standard Progressive Lenses	$0	N/A
Premium Progressive Lenses	$40	N/A
Ultra-Progressive Lenses	$90	N/A
High-Index Lenses	$60	N/A
Plastic Photosensitive Lenses (Transitions)	$70	N/A
Scratch Protection Plan: Single Vision/Multifocal Lenses	$20/$40	N/A
UV Treatment	$12	N/A
Tint (Solid and Gradient)	$0	N/A
Standard Polycarbonate–Adults	$35	N/A
Standard Polycarbonate–Kids Under 19	$0	N/A
Standard Anti-Reflective Coating	$40	N/A
Premium Anti-Reflective Coating	$55	N/A
Ultra-Anti-Reflective Coating	$69	N/A
Polarized	$75	N/A
Other Add-Ons and Services	$20 discount (where applicable) balance from insured frame purchase: 30% discount on additional pairs of eyeglasses	N/A
Standard Plastic Lenses		
Single Vision	$0 copay	N/A
Bifocal	$0 copay	N/A
Trifocal	$0 copay	N/A
Lenticular	$0 copay	N/A
Contact Lens Fit & Follow-up (contact lens fit and follow-up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-up	$0 copay, covered in full	N/A
Specialty Contact Lens Fit & Follow-up	$0 copay, up to $50 allowance plus 15% discount on any overage	N/A
Contact Lens Fit (contact lens allowance includes materials only)		
Conventional and Disposable	$0 copay, $100 allowance, 15% of balance over $100	N/A
Medically Necessary	$0 copay, covered in full (prior approval required)	N/A
Laser Vision Correction		
Laser Vision Coverage	40-50% off the national average price of tradional LASIK	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Health Care and Dependent Day Care Flexible Spending Accounts are administered by Optum Financial.

You can save money when you use pre-tax dollars from a Health Care Flexible Spending Account (HCFSA) or Dependent Day Care Flexible Spending Account (DCAP) to pay eligible health care expenses and dependent day care expenses. Your decision to participate in these voluntary accounts should be based on your needs and personal situation.

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical or dependent day care expenses.

When you contribute to an FSA:

- You decide how much to contribute. You elect an annual contribution in which deductions are taken in equal amounts for the number of remaining pay periods in the plan year
- These contributions can be used for eligible expenses incurred in the calendar year (January 1 through December 31), as well as eligible expenses incurred January 1 through March 15 of the following calendar year. Although the plan year ends December 31, there is a grace period until March 15 to incur claims with any unused funds, and you must submit outstanding claims for reimbursement by March 31
- You save on taxes since your contributions are deducted from your pay **before federal income tax, state income tax, and Social Security taxes are calculated**. You are not taxed on the money you use from your account for eligible expenses
- You cannot change your elections after your enrollment period unless you experience a QLE
- Any money not used will be forfeited. Therefore, it is important to estimate your contribution amounts wisely
- **You must enroll during the annual Open Enrollment period for FSA participation for the next year. If you do not enroll, you will not have an account**

HEALTH CARE FSA

The Health Care FSA allows an annual contribution of $250 to $2,850 in pre-tax money to pay for eligible out-of-pocket health care expenses, including physician office copays, health plan deductibles, prescription drugs, and dental and vision expenses. You also can use funds for your spouse or federal tax dependents. For a complete list of eligible expenses, visit: **www.optumfinancial.com**

USING YOUR FSA FUNDS

Debit Card

Optum Financial will provide you with a debit card you can use to pay for eligible expenses when you incur them.

Submit a Claim

You can also submit a claim using a smart phone or online. You can choose to have eligible reimbursements either deposited directly into your bank account or a check mailed to your home address.

These plans are governed by IRS regulation. If you are questioning the eligibility of an expense, visit the eligible expense list at **www.optumfinancial.com**.

FSA Claim Deadlines

You have until March 15, 2023 to use your remaining FSA balance for plan year 2022. Any balance remaining after March 15, 2023 will be forfeited. All claims for 2022 must be submitted by March 31, 2023.

DEPENDENT DAY CARE FSA

The Dependent Day Care Flexible Spending Account allows an annual contribution of $250 to $5,000 and lets you save pre-tax money for reimbursement of eligible dependent day care or elder care expenses. **Note: the Dependent Day Care FSA is not for the payment of your dependents' eligible health care expenses.**

This is an account for eligible expenses including childcare or certain elder care expenses if you have children under age 13 who attend a licensed day care center, before or after school care, or summer day camp; or if you provide care for a dependent who is mentally or physically incapable of caring for himself or herself.

These plans are governed by IRS regulation. If you are unclear on the eligibility of an expense, visit the eligible expense list at **www.optumfinancial.com**.

Unlike the Health Care FSA, you may only receive reimbursements for services already incurred, and only up to the available funds in your account. An expense is incurred when a service is received—not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service is provided.

To reimburse yourself from your Dependent Day Care FSA, you must pay for the care and then submit the appropriate supporting documentation and Reimbursement Claim Form. All reimbursement requests must include a completed and signed Provider Certification form.

If you do not have a Provider Certification form, submit an itemized statement from the provider that includes:

- Start and end dates of service
- Dependent's name and date of birth
- Itemization of charges
- Provider's name, address and tax ID or Social Security number

The form can be located at:
www.optumfinancial.com

SAVE YOUR RECEIPTS!

Supporting documentation of the expenses and payment may be required for your debit card transactions:

- Explanation of Benefits
- Itemized receipt from your provider

Credit card statements and cancelled checks do not meet the requirements for acceptable documentation.

By federal law, any funds remaining in these accounts at the end of the grace period cannot be rolled over or refunded.

OPTUM Financial™

COMMUTER BENEFIT

Regardless of how you get to work, the Commuter Benefits Program lets you pay for your eligible transit expenses and, now eligible on a pilot basis, work-related parking expenses through automatic, pre-tax payroll deductions. Ordering is handled directly through Optum Financial either online or over the phone. You can request that funds be deposited into your Ventra account or onto an EdenRed Commuter card, or that a monthly transit pass to be mailed to your home.

You can enroll, change your product or funding amount, or cancel at any time. Orders must be submitted by the 10th of the month for the following month. Just visit **www.optumfinancial.com** or call 1-844-284-6267. Representatives are available 24 hours per day, seven days per week.

1-844-284-6267
www.optumfinancial.com

MetLife

PROTECT YOUR FUTURE INCOME FOR YOU AND YOUR LOVED ONES

The County provides basic term life insurance at no cost to you. You have an opportunity to buy more coverage through the County's group insurance policy. You may contact the insurance providers at any time to learn more.

Group Term Basic Life Insurance: Totally County paid, this coverage is equal to one times salary rounded to the next highest thousand for a full-time employee. This plan provides a benefit in the event of death of an employee. Coverage can be converted or ported to an individual policy upon separation from employment. The maximum benefit is $750,000.

Supplemental Group Term Life Insurance: You may purchase additional group term coverage equal to one, two or three times salary, upon employment. During Open Enrollment periods, current participants can increase their coverage within plan, and new enrollments require Evidence of Insurability. Enrollment at other times or increases in amounts require Evidence of Insurability. Payment is made through convenient payroll deduction at reasonable group rates based on age. Coverage can be converted or ported to an individual policy upon separation from employment.

Please note: Proof of good health may be required if you are increasing the amount of insurance to 4X-5X your annual earnings, up to $500,000.

VOLUNTARY BENEFITS

Cook County offers voluntary benefits options through Mercer, administered by Benefit Harbor. These plans are a beneficial tool to help protect your financial security. Employees are encouraged to review all plans available prior to making benefits selections, considering your family's needs. Payment for these voluntary benefits is conveniently available through payroll deduction.

The following plans are available:

Group Accident Insurance

- Accident Insurance pays a lump sum benefit directly to you (unless otherwise assigned) for injuries caused by a covered accident

Group Critical Illness Insurance

- Critical Illness Insurance pays a lump sum benefit upon diagnosis of a covered critical illness, such as a heart attack, stroke, or internal cancer

Group Hospital Indemnity Insurance

- If you have a covered illness or injury, which results in hospitalization, Hospital Indemnity Insurance pays out a lump sum regardless of the cost of care

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Short-Term Disability Insurance

- An injury or sickness may slow you down, but it won't slow down your monthly bills. Short-Term Disability Insurance provides a monthly benefit if you are disabled from an off-the-job injury and cannot work

Universal Life Insurance

- A death not only leaves behind loved ones but also potentially overwhelming financial obligations. Universal Life Insurance provides your beneficiary a lump-sum cash benefit in the event of your death

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Identity Theft Protection

- IDShield provides identity theft protection and identity restoration services for you and your family

Legal Service Plan

- LegalShield provides you with direct access to a dedicated law firm who will answer your personal legal questions and help resolve life's legal matters

Employees should carefully consider which of the optional products the County offers meet their needs for life insurance, disability insurance, medical and dental care, and supplemental insurance.

*Detailed information about these products is available online at **www.cookcountyvoluntarybenefits.com** or by calling 1-800-698-2849. The Department of Risk Management does not provide advice regarding these insurance products.*

DEFERRED COMPENSATION RETIREMENT PLAN

The 457 Deferred Compensation Plan program is a supplemental retirement plan that can help boost your retirement income. Added benefits to contributing to the deferred compensation plan include tax-deferred contributions—possible tax-free earnings/gains.** Starting small can have a great impact on your retirement savings in the long run. Contact your designated Retirement Specialist today to get started!

Minimum payroll deduction to start account	$25 per pay period
Contribution limits if you are under the age of 50	$20,500 for 2023*
Contribution limits if you are over age 50	**Over age 50 catch-up:** $6,500 in addition to the $20,500* **Pre-retirement catch-up** provision available Please contact your local Retirement Specialist for more information.
Age at which you must begin taking distributions	70½ is the Required Minimum Distribution age in which distributions are required in-service or once termed. Please contact Nationwide for further information.
Penalty for early withdrawals	Distributions before 70½ are not permitted.
Taxation	All distributions are subject to federal and state income tax. Please consult your tax preparer for additional information.
Who can participate?	All full-time and part-time Cook County Government and Forest Preserve District employees.

www.cookcountydc.com
1-855-457-2665

*Contribution limits are subject to change annually due to IRS regulations.
**Please speak to your Retirement Specialists regarding these provisions.

EMPLOYEE ASSISTANCE PROGRAM

The Cook County Employee Assistance Program (EAP) is available to help you with balancing the demands of family, work and personal needs. The EAP is administered by Magellan Health and is staffed by licensed professionals available to help you at no cost, 24 hours/7 days a week.

The EAP program is here to help you and your household members along the journey of life–no situation is too big or too small. Services include telephonic goal-oriented coaching, counseling, online programs and digital self-care tools.

Counseling is available for the entire family–individuals, couples and teens (with parental consent and in accordance with applicable law and clinical appropriateness).

Virtual therapy is available in four modalities: text message exchange over a week, live phone, live video or live chat. There are five EAP visits available at no cost–per individual, per issue. If additional services are needed, the appropriate health benefits plan applies.

All services are confidential and can be accessed over the phone at **1-800-327-5048** or online at **www.MagellanAscend.com**.

WELL-BEING

Wellness Wednesday Email Communications: Based on the five core elements of well-being: 1) having a sense of purpose, 2) physical health, 3) financial health, 4) community engagement, and 5) maintaining social connections, weekly emails help you explore real-world strategies designed to help you manage your physical, financial, and mental health.

Employee Benefits Quarterly Newsletter: Keeps you up to date on important information about your benefits and upcoming events. Published in the spring, summer, fall and winter.

Blue Cross Blue Shield of Illinois – Well onTarget: Designed to give you the support you need to make healthy choices. With Well onTarget, you have access to a convenient, secure website with personalized tools and resources such as digital self-management programs, health and wellness content, and tools and trackers.

MyHealth Connection Facebook Community: Focuses on providing preventive care tips and information. Prevention can reduce risk factors that lead to chronic disease or slow the progression of a disease. It's a way to help Cook County employees enjoy longer, healthier and more productive lives.

Health Fair: The annual Employee Health Fair includes a combination of on-site and virtual programs. Flu shots are provided annually at Open Enrollment on-site events and at CVS Health locations for employees and for enrolled dependents through the health plan.

DEFINITIONS

The language of health insurance can be hard to understand. Yet it is important to have a basic knowledge of the industry's terminology. Here are some of the most common financial insurance terms to help you make sense of it all–so you can make smart decisions that will benefit you and your family.

Balance Bill – The difference between the amount charged by an out-of-network provider for a covered health service and the amount your health plan (insurance) pays.

Coinsurance – A percentage of the cost of covered health services you pay. This often starts after the deductible is satisfied.

Copayment – A fixed dollar amount you pay for covered health services such as a physician visit.

Deductible – A fixed, annual amount you pay for covered health services before the health plan (insurance) starts to pay. For certain services, such as in-network preventive care, you are not required to first satisfy the deductible.

Dual Coverage – The same person is enrolled under more than one of Cook County's employee benefits. Dual coverage is prohibited for employees and dependents on all County plans.

In-Network – A group of doctors, hospitals, pharmacies, and other providers who contract with the health plan and provide services at negotiated rates.

Out-of-Network – A group of doctors, hospitals, pharmacies, and other providers who do not contract with the health plans and do not provide services at negotiated rates. You pay more out of pocket and have fewer protections. Out-of-network providers may balance bill you for these costs.

Out-of-Pocket Maximum – The maximum annual out-of-pocket amount you pay before the health plan (insurance) pays 100% of covered health services. For out-of-network services, providers may balance bill even after the out-of-network, out-of-pocket maximum is reached.

Premium – The amount you pay for health insurance.

Pre-Tax Contributions – Pre-tax contributions include the premium costs for the medical coverage you elect, as well as any contributions you choose to make to a Health Care Flexible Spending Account (HCFSA), Dependent Care Flexible Spending Account (DCAP), Commuter Benefit, and Deferred Compensation Plan up to Federal tax limits. Pre-tax contributions are deducted from your pay before federal and state income taxes and Medicare taxes are calculated, reducing your taxable income (and the current taxes you pay).

USE IN-NETWORK PROVIDERS TO SAVE MONEY

While it may be a personal preference to use out-of-network providers, there are some protections you lose by doing so.

1. The health plans do not contract with out-of-network providers, which means they don't check into providers' history such as their medical license, education, training, work history, malpractice claims, board certification, health outcomes, etc.

2. Out-of-network providers may balance bill you, which means billing you for the difference between the amount they charge you for a covered service and the amount your insurance pays.

3. Overall, you pay more out of pocket for out-of-network services.

REMINDERS

Consequences of Fraudulent Enrollment

Any kind of fraud on the County's benefit plans may result in adverse consequences to an employee and dependent, for example:

- Failure to notify the Department of Risk Management of an event that would cause coverage to end, e.g., divorce
- Misrepresentation by the employee or dependent regarding the initial eligibility, for example, the dependent's age, or that the dependent is not a legal dependent of the employee
- Any attempt to assign or transfer coverage to someone else (e.g., letting another person use your Plan ID card)

The employee may be required to pay for any claims and all administrative costs that were incurred fraudulently. This may result in coverage being terminated for the employee and action by the County to collect any money paid. The County may also discipline the employee, up to and including termination.

NOTICES

Important notices regarding Cook County Employment Benefits may be found at: **www.cookcountyil.gov/service/compliance**

These notices include:

- Health Insurance Marketplace Coverage
- Cook County's Group Health Plan Notice of Privacy Practices
- COBRA Election Notices
- Women's Health and Cancer Rights Act of 1998
- 1095 Tax Reform Request
- Notice to Enrollees of Mental Health Parity and Addiction Equity Act Exemption for 2021

IMPORTANT BENEFITS CONTACT INFORMATION

MEDICAL PLANS

Blue Cross Blue Shield of Illinois
www.bcbsil.com/cookcounty

BlueAdvantage HMO
Group #B03351
1-800-892-2803

Blue Cross Blue Shield PPO
Group #291116
1-800-960-8809

PHARMACY BENEFIT PLAN

CVS Pharmacy
www.caremark.com
1-866-409-8522

GROUP TERM LIFE AND SUPPLEMENTAL LIFE INSURANCE

MetLife
www.metlife.com/mybenefits
Group/Customer #227860
1-866-492-6983

DENTAL PLANS

Guardian
www.guardiananytime.com/cookcounty
Group #397485
Dental HMO: 1-866-494-4542
Dental PPO: 1-866-302-4542

VISION PLAN

Davis Vision
www.davisvision.com/member
1-800-381-6420

FLEXIBLE SPENDING ACCOUNTS AND COMMUTER BENEFITS

Optum Financial
www.optumfinancial.com
1-844-284-6267

COOK COUNTY VOLUNTARY BENEFITS

Mercer
www.CookCountyVoluntaryBenefits.com
1-800-698-2849

DEFERRED COMPENSATION

Nationwide
www.cookcountydc.com
1-855-457-2665

EMPLOYEE ASSISTANCE PROGRAM

Magellan
www.MagellanAscend.com
1-800-327-5048

JOIN THE FACEBOOK GROUP MYHEALTH CONNECTIONS

MyHealthConnections
www.facebook.com/groups/Myhealthconnections

Cook County Department of Risk Management
Employee Benefits Division
118 N. Clark Street, Suite 1072 • Chicago, IL 60602
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www.cookcountyrisk.com • Email: risk.mgmt@cookcountyil.gov

COOK COUNTY
BENEFITS CONNECT