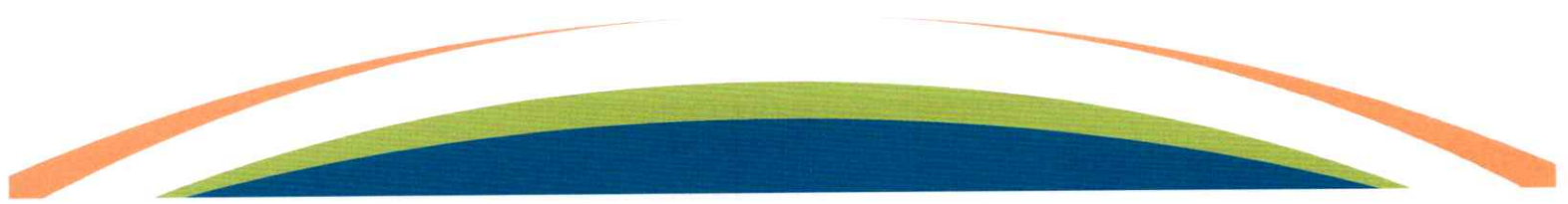




Employee Benefits Summary

January 1, 2026 - December 31, 2026

IMPORTANT INFORMATION ENCLOSED



Our Promise

We are committed to providing our greatest assets – our people – with comprehensive and affordable benefits. Our 2026 Employee Benefits offerings deliver maximum options and flexibility. This guide will help you understand the full range of health and wellness benefits that will be available. After reading through the enclosed information, be sure to use this guide as a benefits resource you can reference throughout the year.

This guide includes a quick reference directory of telephone numbers and websites for all of our providers. We encourage you to access these sites to learn more about the plans and make the best choices possible.

Protect your **Health, Life & Well-Being**

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Medical Insurance

About the Medical Insurance

Choosing the right health insurance plan is important for you and your family. The following are some of the basic reasons you should obtain health coverage.

- Health insurance gives you a sense of security knowing that a sudden illness or serious injury will not drain your bank account, or worse, your retirement savings. Health insurance protects your financial future by helping pay for expensive doctor visits and treatments.
- Seeing doctors who are in-network with your health insurance plan also gives you the advantage of receiving care with lowered costs. When doctors are in-network, you have access to lower rates negotiated by the insurance company, meaning you owe less than if you did not have insurance.
- Health insurance covers many preventative services without you having to pay a deductible or copayment. Preventative care is intended to prevent or catch diseases and other health problems before they become serious. Preventative services that are covered in full include various health screening and immunizations
- Having health insurance will also help you pay for prescription drugs through reduced fees or copays.



Who is Eligible?

Full-time employees who work a minimum of 30 hours and their family members are eligible to enroll in the benefits described in this guide. *Children can remain covered up to age 26 for all lines of coverage.*

When are you Eligible?

Newly Eligible Employees:

Benefits are effective on the first day of full-time employment.

Annual Open Enrollment:

You may make changes to your benefit elections during your open enrollment period November for an effective date of January 1st.

Qualified Change in Status:

You may make benefit changes within 30 days of a qualified event. Qualified events include marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death, and change in residence due to an employment transfer for you or your spouse or changed in spouse's benefits, or employment status.

Note: Employee is responsible for notifying Human Resources of any changes within 30 days.

Medical Insurance- BlueCross BlueShield of IL

COVERAGE	PPO Grandfathered Plan		H.S.A		Blue Advantage HMO Grandfathered Plan
	PPO		PPO		HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Annual Deductible					
Individual	\$500	\$1,000	\$3,400	\$5,200	\$0
Family	\$1,500	\$3,000	\$6,800	\$10,400	\$0
Annual Out-of-Pocket Maximum					
Individual	\$1,500	\$3,000	\$3,400	\$10,400	\$1,500
Family	\$4,500	\$9,000	\$6,800	\$20,800	\$3,000
Coinsurance	10%	30%	0%	20%	0%
Lifetime Maximum	Unlimited		Unlimited		Unlimited
Physician & Services					
Primary Care Physician	\$20 Copay	30% after Ded.	No Charge after Ded.	20% after Ded.	\$15 Copay
Specialist Care Physician	\$20 Copay	30% after Ded.	No Charge after Ded.	20% after Ded.	\$15 Copay (Referral Required)
TeleMedicine	\$20 Copay	N/A	Subject to Ded. and coinsurance	N/A	\$15 Copay
Preventative Care	No Charge	30% after Ded.	No Charge	20% after Ded.	\$15 Copay
Urgent Care	10% after Ded.	30% after Ded.	No Charge after Ded.	20% after Ded.	\$15 Copay (must be affiliated with medical group or referral required)
Hospital Services					
Inpatient	10% after Ded.	\$250 Copay, then 30% after Ded.	No Charge after Ded.	\$300 Copay, then 20% after Ded.	No Charge (Referral Required)
Outpatient	10% after Ded.	30% after Ded.	No Charge after Ded.	20% after Ded.	No Charge (Referral Required)
Emergency Room	\$50 Copay (copay waived if admitted)		No Charge after Ded.		\$50 Copay (copay waived if admitted)
PRESCRIPTION RX COVERAGE					
	PPO Grandfathered**		H.S.A		Blue Advantage HMO
In-Network Retail (Up to a 34-Day Supply)	Generic: \$10 Preferred Brand: \$20 Non-Preferred Brand: \$35 Specialty: 35 Copay		No Charge after Ded.		Generic: \$10 Preferred Brand: \$20 Non-Preferred Brand: \$35 Specialty: 35 Copay
In-Network Mail Order (Up to a 90-day Supply)	Generic: \$20 Preferred Brand: \$40 Non-Preferred Brand: \$75		No Charge after Ded.		Generic: \$20 Preferred Brand: \$40 Non-Preferred Brand: \$70
Out-of-Network	Generic: \$10 Preferred Brand: \$20 Non-Preferred Brand: \$35 Specialty: Not Covered		No Charge after Ded.		N/A

**For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after the copayment
See Certificate of Coverage for full policy details including limits and exclusions - for a copy see Human Resources.
To identify an in-network provider go to www.bcbsil.com.

Medical Insurance- BlueCross BlueShield of IL

COVERAGE	Blue Choice Options PPO		
	Tier 1 Blue Choice Options (BCO)	Tier 2 PPO	
	In-Network	In-Network	Out-of-Network
Annual Deductible			
Individual	\$500	\$1,500	\$3,000
Family	\$1,500	\$4,500	\$9,000
Annual Out-of-Pocket Maximum			
Individual	\$2,000	\$5,600	\$16,800
Family	\$6,000	\$10,200	\$30,600
Coinsurance	10%	30%	50%
Lifetime Maximum	Unlimited		
Physician & Services			
Primary Care Physician	\$20 Copay	\$50 Copay	50% after Ded.
Specialist Care Physician	\$40 Copay	\$100 Copay	50% after Ded.
TeleMedicine	\$20 Copay	\$20 Copay	50% after Ded.
Preventative Care	No Charge	No Charge	50% after Ded.
Urgent Care	\$75 Copay	\$75 Copay	\$75 Copay
Hospital Services			
Inpatient	\$250 Copay, then 10% after Ded.	\$500 Copay, then 30% after Ded.	\$600 Copay, then 50% after Ded.
Outpatient	\$200 Copay, then 10% after Ded.	\$400 Copay, then 30% after Ded.	\$500 Copay, then 50% after Ded.
Emergency Room	\$400 Copay, then 10% after the Ded.		
PERScription DRUG COVERAGE	See following page for RX details		

See Certificate of Coverage for full policy details including limits and exclusions - for a copy see Human Resources.

Blue Choice Options (BCO) - The Blue Choice Options PPO network has many doctors and hospitals that can meet all your health care needs. They all meet BlueCross and BlueShield of Illinois (BCBSIL) quality standards and have agreed to offer you care and services at a lower cost.

- ***Tier 1:** Blue Choice Options PPO Network - Best value, the least out-of-pocket costs with in-network providers
- ****Tier 2:** Larger Statewide PPO Network - Larger network, more out-of-pocket costs with these providers
- **Out-of-Network:** Highest out-of-pocket costs, you may have to pay those fees up front

Tier 1 Hospitals	Tier 2 Hospitals Only
<ul style="list-style-type: none"> • Advocate Hospital System • Adventhealth • Endeavor Health System • Loyola University Medical Center • Northwestern Hospital System • Rush Hospital System 	<ul style="list-style-type: none"> • Ann & Robert Lurie Children's • Ingalls Memorial Hospital • University of Chicago Medical Center

Please Note: This is not a full list of In-Network Providers and contracted providers can regularly change. For a complete and up-to-date list of In-Network Providers please visit www.bcbsil.com.

Medical Insurance - BlueCross BlueShield of IL



<i>Blue Choice Options PPO</i>		
RX COVERAGE	Preferred Drugs	Non-Preferred Drugs
Preferred Participating Retail Pharmacy (30 Day Supply)	Generic: \$0 Copay Brand: \$35 Copay Specialty: \$150 Copay	Generic: \$10 Copay Brand: \$75 Copay Specialty: \$250 Copay
Non-Preferred Participating Retail Pharmacy (30 day supply)	Generic: \$10 Copay Brand: \$55 Copay Specialty: \$150 Copay	Generic: \$20 Copay Brand: \$95 Copay Specialty: \$250 Copay
Mail Order (90 day supply)	Generic: \$0 Copay Brand: \$70 Copay Specialty: N/A	Generic: \$20 Copay Brand: \$150 Copay Specialty: N/A
Out-of-Network	Generic: \$10 Copay Brand: \$55 Copay Specialty: \$150 Copay	Generic: \$20 Copay Brand: \$95 Copay Specialty: \$250 Copay

***All prescriptions filled at an Out-of-Network Pharmacy are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts.

NOTE: If you're enrolled in the BlueChoice Options PPO plan please make sure to use Preferred Participating Pharmacies so that you get the best rate for your prescription drugs.

PPO Preferred Participating Pharmacies:

- Walgreens
- Walmart / Sam's Club
- Albertsons -OSCO, Safeway
- Health Mart Atlas - independently owned and operated pharmacies



Non-Preferred Participating Pharmacies:

- Other chain pharmacies, vary by state

Medical Insurance (How to Find a Preferred Retail Pharmacy)

BlueCross and BlueShield of IL

Visit [MyPrime.com](https://www.myprime.com), click “Find a Pharmacy,” and select “Continue without sign in.”

1. Select your Health Plan as “**BCBS Illinois.**”
2. Select “**No**” to being a Medicare Part D member and “**Other BCBSIL Plans**” as the Health Plan Type, then select “**Continue.**”
3. On the Find a Pharmacy page, select “**Preferred Network**” and press “**Submit.**”
4. On the Pharmacy Search Results page, select “**Retail,**” then enter your city, state, ZIP code or address to search for pharmacies in your network. Since all in-network retail pharmacies will be listed, you can filter by “**Preferred pharmacies**” to find specific locations in your Preferred Pharmacy Network.

Your network: Preferred Network [Change your network](#)

In-network pharmacy search results


for Retail pharmacies | [View or change search criteria](#)


Note: Pharmacy search results are based on current plan year information only. [Sign in](#) or [register](#) to get prices and in-network pharmacies specific to your benefits.

Filters ▾ Sort by price ▾

20 pharmacies in your network

Sign in to price a medicine here	<p><u>Walgreens #4252</u></p> <p>10 E St Charles Villa Park, IL 60181 0 miles 630.832.6030</p>	<p>P Preferred pharmacy</p> <ul style="list-style-type: none">✓ 90-day supply available✓ Vaccine pharmacy✓ eRx available
Sign in to price a medicine here	<p><u>Osco Drug #3284</u></p> <p>31 E Saint Charles Rd Villa Park, IL 60181 0.1 miles 630.279.8900</p>	<p>P Preferred pharmacy</p> <ul style="list-style-type: none">✓ 90-day supply available✓ Vaccine pharmacy✓ eRx available
Sign in to price a medicine here	<p><u>Villa Park Pharmacy</u></p> <p>616 N Addison Rd Villa Park, IL 60181 1 miles 630.501.0751</p>	<ul style="list-style-type: none">✓ Vaccine pharmacy✓ eRx available

Redo search in map 



Map showing search results in Lombard, IL. The map displays several blue location markers and major roads like I-55 and I-290. A red arrow points from the 'Walgreens #4252' listing to the map.

Home delivery

Home delivery brings a 90-day supply of your medicines straight to your door.

[Learn more](#)

Specialty medicines

Get personalized support for complex, chronic conditions and medicines that treat them.

Medical Insurance (Provider Finder)

BlueCross and BlueShield of IL

For routine care, or to find specialty providers, you can also use the provider finder tool. This is a convenient way to search and locate a health provider/facility that fits your needs.

To get started, go to www.bcbsil.com

- Select “Find Care”
- Then choose “Find a Doctor or Hospital”
- Then search as a guest.

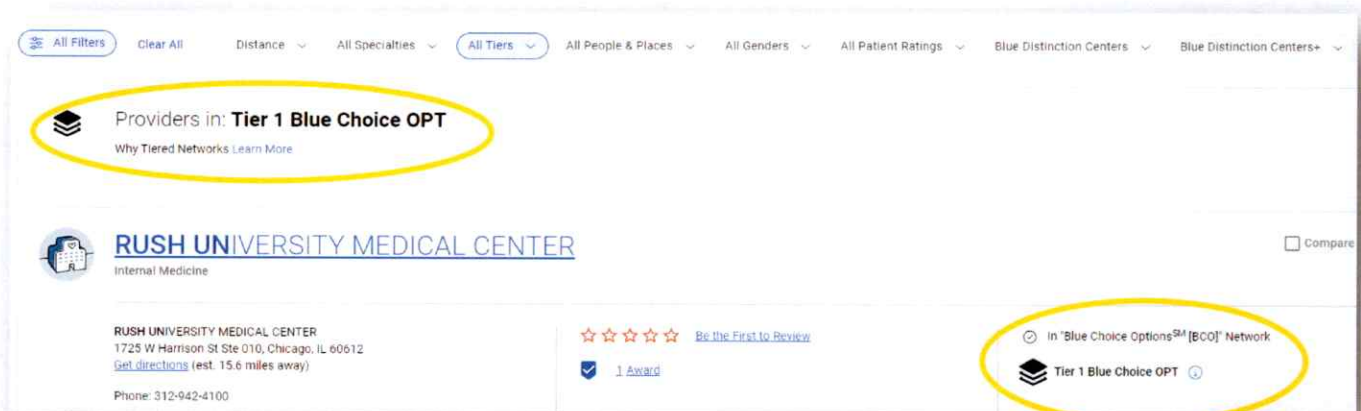


Searching is simple:

Enter your zip code, then you will need to select your plan

- Select Blue Advantage HMO [ADV] for the Grandfathered HMO Plan
- Select Participating Provider Organization [PPO] for the Grandfathered PPO Plan & HSA Plan
- For the new Blue Choice Options Plan
 - Select Blue Choice Options PPO [PPO] for Tier 1 providers & facilities
 - Select Participating Provider Organization [PPO] for Tier 2 providers & facilities

Search for a specific provider or facility name, or find healthcare by choosing a category and Blue Cross will provide you with a list of In-network providers and facilities near you.



Blue Cross Blue Shield of IL Value Adds

BCBS of IL provides several additional perks, just for being a member on the health plan! For more information visit www.bcbsil.com and login to your Blue Access for Members Portal (BAM).

BCBSIL Member Services

Blue Access for Members

Get information about your health benefits, anytime, anywhere. Use your computer, phone, or table to access the Blue Cross Blue Shield of Illinois secure member website, Blue Access for Members (BAM).

BlueCard

Available to Most Members

Through the Blue Card PPO Program, BCBS plans work together to help ensure you receive reliable, affordable health care when you need it while traveling in the U.S. You have access to an established PPO network of doctors, hospital and other health care providers throughout the country. To find a provider near you, call BlueCard Access at **800-810-2583** or visit www.bcbsil.com

Mental Health Services

Digital Mental Health- Learn to Live

PPO Members Only

Self-paced private and confidential coaching available 24/7 at no cost to you and your family. Online programs and clinical assessments based on the proven principles of Cognitive Behavioral Therapy including Stress, Anxiety and Worry, Social Anxiety, Insomnia, and Substance Abuse. Must be aged 13 and older to participate.

Wellbeing Management Services

Well on Target Digital Program

Available to PPO & HMO Member

Well onTarget offers Digital Self-Management Programs to help you develop a healthier lifestyle. Easy to access through the Well onTarget Member Wellness Portal at wellontarget.com

Well on Target Fitness Program

Well onTarget offers personalized tools and resources to help you - no matter where you may be on the path to health and wellness. For more information, call **888-762-2583**.

Blue Cross Blue Shield of IL Value Adds

BCBS of IL provides several additional perks, just for being a member on the health plan! For more information visit www.bcbsil.com and login to your Blue Access for Members Portal (BAM).

Virtual Visits

MDLIVE

Available to Most PPO Members

For a cost that's less than an urgent care or ER visit, MDLIVE gives you 24/7/365 access to U.S. board- certified doctors by web, phone, or mobile app. It's a more convenient and affordable option for quality medical care. Visit BAM or www.MDLIVE.com/bcbsil to request a virtual visit to speak with a doctor. Or, you may request a consult by phone at **888-676-4204**.

Blue365

Available to Most PPO Members

BCBS of IL members have access to Blue365, a discount program exclusively for Blue Cross Blue Shield members. With this program, you can save money on health and wellness products and services that are not covered by insurance. There are no claims to file and no referrals or pre- authorizations. Get started today at www.Blue365Deals.com/register.

Prescription & Pharmacy

Specialty Medications Accredo

Specialty medications for complex and/or chronic conditions can be filled through Accredo. To start using Accredo, call **833-721-1619** and an a representative will work directly with your doctor on the rest.

Mail Order Pharmacy Available to PPO & HMO Member

Express Scripts Pharmacy delivers your long-term (or maintenance) medicines right to your home. No driving to the pharmacy or waiting in line for your prescription to be filled. Register online at express-scripts.com/rx or call **833-715-0942**

Health Savings Account



A Health Savings Account (HSA) is a type of tax-free savings account that lets you save for current and future qualified medical expenses while reducing your pretax dollars. Using an HSA to pay for deductibles, copayments/coinsurance and other qualified medical expenses is another way to lower your overall health care costs. Specific requirements must be met to have an HSA. Any unused funds at the end of the calendar year will be rolled into the next calendar year.

Some details to keep in mind:

- In order to establish an HSA, you have to be covered by a High Deductible Health Plan. These types of plans have no co pays.
- The IRS sets an annual maximum amount that can be deposited into the account. Any unused funds will earn interest and roll over from year to year. These funds belong to you — if you leave your job, you take the money in the account with you.
- As long as funds are withdrawn for qualified medical expenses, they will be tax-free. If funds are taken for other expenses, you will pay income tax and a 20% penalty on the withdrawal.
- The owner of the HSA account is responsible to keep records on all withdrawals. Keep all receipts for medical expenses paid for with HSA money in case you are audited.

Who is eligible for a HSA?

- Must be enrolled in a high-deductible health insurance plan (HDHP).
- Do not have another first-dollar medical coverage, or enrolled in Medicare, or Tricare.
- Is not covered by another health plan that is not a HDHP.
- Cannot be claimed as a dependent on someone else's tax return.

Contributions and Out-of-Pocket Limits for Health Savings Accounts and HDHPs*

	2026	2025
HSA Contribution Limit* (employer + employee)	Self-only: \$4,400 Family: \$8,750	Self-only: \$4,300 Family: \$8,550
HSA Catch-up Contributions* (Age 55 or older)	\$1,000	\$1,000

Source: IRS, Revenue Procedure 2021- 26

* Please visit www.thehortongroup.com/limits for the most current IRS approved limits.

Flexible Spending Account (FSA)

WEX

A Flexible Spending Account (FSA) allows you to pay for qualified Health Care and Dependent Care expenses using tax-free dollars. The amount you elect is deducted from your paycheck pre-tax. This means you don't pay Federal Income Tax or Social Security Taxes on that portion of your paycheck. The money that is deducted is then used to reimburse your eligible qualified expenses.

Health Care FSA

A Health Care FSA allows you to pay for unreimbursed health care expenses for you, your spouse and dependent children. You do not need to be on your employer sponsored health plan to sign up for a FSA.

One of the biggest advantages of the Health Care FSA is that you can access your entire elected amount on the first day of the plan year. So, there's no need to wait until funds have been payroll deducted to use your FSA.

As you plan your FSA expenses for the year, it is important that you make accurate and conservative estimates.

Annual maximum you may contribute is \$3,400 per-calendar year.

Elections can only be changed during open enrollment or a qualified event.

Limited Care

A limited-purpose health flexible spending account (referred to as a limited-purpose FSA) is much like a typical, general-purpose health FSA; however, under a limited-purpose FSA, eligible expenses are limited to qualifying dental and vision expenses. If contributing to a HSA, this is the only FSA available to you.

Dependent Care FSA

Dependent Care FSA allows you to pay for child or elder care expenses using tax-free dollars. These expenses must be incurred while you are employed and must be for the care of a qualified dependent.

Unlike the Health Care FSA, Dependent Care FSA funds are not available to you on day one. These funds must accumulate before you can reimburse yourself, and you can only be reimbursed up to the amount you have in the account at any given time. **Annual maximum you may contribute is \$7,500 (or \$3,750 if married and filing separately) per-calendar year.**

Dependent Care election amounts can be changed during the year as cost changes.

Flex Debit Card

The Flex Debit Card allows you to pay for your healthcare needs on the spot at qualified locations without having to wait for a reimbursement check. The card can be used at hospitals, physician offices, dental offices, vision service providers and pharmacies. Copies of receipts for some expenses still need to be submitted.

- Payment comes directly from your Health Care FSA account, which reduces your out-of-pocket expense
- Limits the need to submit claim forms and wait for reimbursement
- FSA plan year is January 1st through December 31st.
- Any changes in election (other than January 1st) can only happen if there is a family status change (Marriage, Divorce, Birth or Death) In order for the employee's child's claims to be paid, the child must be dependent of the employee by IRS.

* Please visit www.thehortongroup.com/limits for the most current IRS approved limits.

How you can use a Health Care FSA:

- Medical Plan Deductibles
- Co-Pays
- Dental Expenses (Including Orthodontics)
- Eye Exams, Glasses and Contacts
- Vision expenses
- Prescription drug expenses
- Over-the-counter supplies like band aids and vitamins

How you can use a Dependent Care FSA:

- Pre-School Charges
- Before-and After-School Care
- Day Care Centers
- Summer Day Camps
- And More

For a complete list, please visit irs.gov/publications/p502.

Dental Insurance



BlueCross BlueShield of IL

Dental care plans provide services or payments for restorative care and related dental services.

Coverage	PPO Low Plan		PPO High Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible- Does Not Apply to Preventative Services				
Individual	\$50	\$75	\$50	\$50
Family	\$150	\$225	\$150	\$150
Calendar Year Maximum	\$1,500	\$500	\$2,000	
Preventive Care Services	10%*	40%**	No Charge	Covered up to 100%**
Basic Services	30%*	60%**	20%*	20%**
Major Services	50%*	75%**	50%*	50%**
Orthodontics Up to age 19	N/A		50%* up to the lifetime maximum of \$1,000	

*You will not be "balance billed" for charges exceeding the Maximum Plan Allowances (MPAs).

**You are responsible for charges exceeding MPAs.

See Certificate of Coverage for full policy details including limits and exclusions - for a copy see Human Resources.

Finding an In-Network Dentist:

For a list of in-network general and specialty dentists, go to bcbsil.com and use the Provider Finder® tool by clicking on **Find Care** and then on **Find a Dentist** on the left side of the page.



Vision Insurance

VSP

Vision care plans provide coverage for the nonsurgical improvement of eyesight, including coverage for eyeglasses and contact lenses. Coverage typically is limited and is subject to applicable copayments or scheduled cash allowances.

	Frequency	In-Network VSP Choice	Out-of-Network
Wellvision Exam	12 Months	\$10 Copay	Reimbursement up to \$40
Essential Medical Eye care	Available	\$20 Per Exam	
Standard Lenses	12 Months		
Single / Vision	12 Months	\$10 Materials Copay	Reimbursement up to \$30
Bifocal	12 Months	\$10 Materials Copay	Reimbursement up to \$50
Trifocal	12 Months	\$10 Materials Copay	Reimbursement up to \$70
Frames	12 Months	\$170 Featured Frame Balance allowance \$150 frame allowance 20% savings on amount over allowance \$150 Walmart/Sam's Club frame allowance \$80 Costco frame allowance	Reimbursement up to \$75
Contact Lens - In lieu of eyeglasses			
Evaluation and Fitting	12 Months	Up to \$60	N/A
Conventional Contacts	12 Months	\$150 allowance	Reimbursement up to \$75
Disposable Contacts	12 Months	\$105 allowance	Reimbursement up to \$75
Medically Necessary Contacts	12 Months	Paid-In-full	Reimbursement up to \$300

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

To identify an in-network provider go to www.vsp.com.



Life Insurance and AD&D



BlueCross BlueShield of IL

Life insurance is a contract between an insurer and a policyholder. A life insurance policy guarantees the insurer pays a sum of money to named beneficiaries when the insured policyholder dies, in exchange for the premiums paid by the policyholder during their lifetime.

Villa Park provides and pays for Group Life and Accidental Death and Dismemberment (AD&D) Insurance for all full-time employees, spouses and dependent child(ren). The beneficiary you designate will receive the Life Insurance benefit in the event the insured policyholder dies.

Please ensure, your Human Resources has up to date beneficiary information.

Full-Time Employee Life Insurance

Amount	\$50,000 Union Employees please refer to your CBA for correct amount.
Accidental Death & Dismemberment	
Amount	\$50,000 Union Employees please refer to your CBA for correct amount.
Benefit Reduction	<ul style="list-style-type: none"> 50% at age 70

Police and Fire Sworn Personnel Insurance

Amount	\$150,000 Union Employees please refer to your CBA for correct amount.
Accidental Death & Dismemberment	
Amount	\$150,000 Union Employees please refer to your CBA for correct amount.
Benefit Reduction	<ul style="list-style-type: none"> 50% at age 70

Spouse Life Insurance

Amount	\$5,000
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Child (ren) Life Insurance

Child (ren) Amounts	<ul style="list-style-type: none"> \$0 Child (ren): Live Birth to 14 days \$100 Child (ren): 15 days to six months \$2,000 Child (ren): 6 months to age 26
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Voluntary Life Insurance and AD&D

BlueCross and BlueShield

In addition to the base insurance plan offered by your employer, your employer also offers you the opportunity to “buy-up” more insurance coverage. Please consider this option if you need more coverage for yourself or your dependents.

Please ensure, your Human Resources has up to date beneficiary information.

	Employee	Spouse	Child(ren)
Amount	Choice of \$10,000 Increments	Choice of \$5,000 Increments up to \$150,000 or 50% of employee's amount Employee must elect coverage on themselves for spouse to be eligible	Child: Birth to 14 days: \$0 Child: 14 days to 6 months - \$500 Child: 6 months to age 26 - Increments of \$1,000 to \$10,000 Employee must elect coverage on themselves for child (ren) to be eligible
Minimum Amount	\$10,000	\$5,000	\$1,000
Maximum Amount	\$500,000	\$150,000	\$10,000
Guarantee Issue Amount	\$100,000	\$30,000	\$10,000
Benefit Reduction	<ul style="list-style-type: none"> • 67% at age 70 • 50% at age 75 	<ul style="list-style-type: none"> • 67% at age 70 • 50% at age 75 	N/A

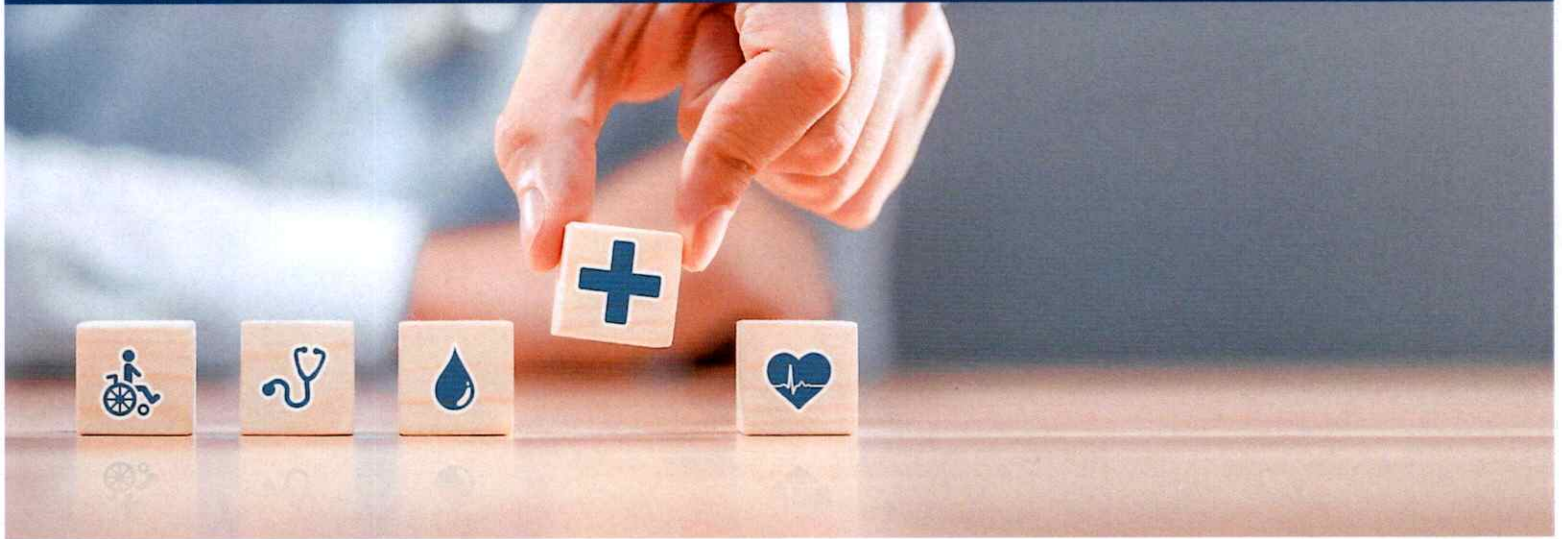
See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

Annual Enrollment:

- Employees currently enrolled, may increase their benefit amount by 1 increment of \$10,000 up to the guaranteed issue amount of \$100,000 without submitting Evidence of Insurability (EOI).
- Any amount above the guarantee issue requires Evidence of Insurability (EOI).
- For Employees without current coverage, Evidence of Insurability (EOI) is required for any benefit election.
- For Spouses, Evidence of Insurability (EOI) is required for all increases and/or new elections.
- For Dependent Children, Evidence of Insurability (EOI) is not required.



Voluntary Short-Term Disability



BlueCross BlueShield

Voluntary Short-term disability (STD) plans provide a weekly benefit to eligible employees that are unable to work for an extended length of time. These benefits are for non-work-related illnesses or accidents on a per-disability basis, typically for a 3 - to 12-month period. Benefits are paid as a percentage of employee earnings or as a flat dollar amount. STD benefits vary with the amount of pre-disability earnings, length of service with the establishment, or length of disability.

VOLUNTARY SHORT-TERM DISABILITY

Benefit Begins	8th day of Disability due to Accidental Injury 8th consecutive day of Disability due to Sickness
Payable Benefit Duration	12 Weeks
Percentage of Income Replaced	60% of Weekly Earnings
Maximum Benefit	\$2,000 Per Week
Pre-Existing Condition Limitation (3/12)	You may not be eligible for benefits if you have been diagnosed or received treatment for a condition within the past 3 months until you have been covered under this plan for 12 months.

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

Voluntary Accident



BlueCross BlueShield

Accident insurance provides you with the extra money you need to help cover the increased expenses, medical or otherwise, you face when you suffer an injury due to an accident. The proceeds from your approved claim may be used however you wish.

ACCIDENT	BENEFIT AMOUNT
Fracture	Up to \$5,000
Dislocation	Up to \$4,000
Burn	Up to \$12,500
Concussion	\$150
Coma	\$12,500
Laceration	Up to \$500
Ground/Air Ambulance	\$200 / \$1,500
Therapy	\$35
Pain Benefit	\$100
Prosthetic Devices	Up to \$1,500
Hospital Confinement	\$250
Surgery	Up to \$1,250
Wellness	\$50
BASIC ACCIDENTAL DEATH AND DISMEMBERMENT	BENEFIT
Employee	\$40,000
Spouse	\$40,000
Children	\$12,500

For full plan features, including exclusions and limitations, please refer to your Certificate of Coverage booklet.

Voluntary Critical Illness

BlueCross BlueShield

Critical Illness Insurance can help with expenses that medical insurance doesn't cover like deductibles or out of pocket costs, or services like experimental treatment. Critical Illness supplements your medical and your disability income insurance.

VOLUNTARY CRITICAL ILLNESS BENEFITS

Benefit Amount: Employee	\$5,000 - \$20,000 in increments of \$5,000
Guarantee Issue Amount - Employee	\$20,000 available at annual enrollment
Benefit Amount: Spouse	\$2,500 - \$10,000 in increments of \$2,500, not to exceed the employee benefit amount.
Guarantee Issue Amount - Spouse	\$10,000 available at annual enrollment
Benefit Amount: Child(ren)	\$2,500 - \$10,000 in increments of \$2,500, not to exceed the employee benefit amount.
Guarantee Issue Amount - Child(ren)	\$10,000 available at annual enrollment
Coverage Maximum	Triple Protection: Up to 3 times the selected benefit amount
Pre-existing Conditions (12/12)	A pre-existing condition is any Illness or Injury for which You received medical treatment for, advice was rendered, prescribed or recommended within 12 months prior to the effective date of Your coverage. A pre-existing condition is not covered within the first 12 months of coverage.
Recurrence Benefit	50% of the following covered conditions: Invasive Cancer, Heart Attack, Stroke, Benign Brain Tumor and Coma. 180 Days for the Separation Period.
Age Reduction Schedule	Benefits reduce by 35% of the original amount at age 65 and further reduce by 50% of the original amount at age 70. Benefits Terminate at Retirement.
Separation Period	180 Days
Portability	Benefits are portable to age 65. Spouse and dependents may port their coverage only if the employee is also ported. You must be covered under the plan for 12 months and under age 60 to be eligible for Portability.
Wellness Benefit	\$50 dollars per calendar year for Employee and covered Spouse

COVERED CONDITIONS

Invasive Cancer	100%	Carcinoma In Situ	25%
Heart Attack	100%	Major Heart Surgery	25%
Stroke	100%	End Stage Renal Failure	100%
Major Organ Transplant	100%	Paralysis	100%
Major Burns	100%	Benign Brain Tumor	100%
Coma-Brain Injury	100%	Loss of Sight, Speech or Hearing	100%
Advanced Alzheimer's Disease	100%	Severe Covid-19 Infection	100%
Advanced Multiple Sclerosis	100%	Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS)	100%		

For full plan features, including exclusions and limitations, please refer to your Certificate of Coverage booklet.

Voluntary Hospital Indemnity

BlueCross BlueShield

A stay in a hospital can be very expensive, even with the best medical insurance. Hospital Indemnity insurance provides a benefit if you are confined in a hospital. The extra money is paid directly to you and can help cover medical bills, deductibles, the increased expenses, medical or otherwise, you face. The proceeds from your approved claim may be used however you wish.

VOLUNTARY HOSPITAL INDEMNITY

Hospital Admission

Payable once per year when admitted to a hospital

\$500

Daily Hospital Confinement

Pays a daily benefit when confined to a hospital for at least 20 hours.
Payable up to 30 days per year.

\$100 per day

Intensive Care Unit (ICU) Admission

Payable once per year when admitted to an Intensive Care Unit of a hospital. This is in addition to the Hospital Admission benefit.

\$500

Daily Intensive Care Unit (ICU) Confinement

Pays a daily benefit when confined to a hospital Intensive Care Unit. This is in addition to the Daily Hospital Confinement benefit. Payable up to 10 days per year. If ICU Confinement exceeds 10 days, the Daily Hospital Confinement benefit will apply.

\$100 per day

Newborn Confinement Benefit

Pays a daily benefit when a newborn child is confined in a hospital to receive routine nursery care while the mother is confined. Payable up to 3 days.

\$50

For full plan features, including exclusions and limitations, please refer to your Certificate of Coverage booklet.

Contact Information



Benefit	Carrier	Phone	Website
Medical	BCBSIL	HMO: 800-892-2803 PPO: 800-541-2768	www.bcbsil.com
Dental	BCBSIL	800-367-6401	www.bcbsil.com
Vision	VSP	800-877-7195	www.vsp.com
Health Savings Account (H.S.A)	Dan McCann	630-592-6061	dmccann@invillapark.com
Flexible Spending Account (F.S.A)	WEX	866-451-3399	www.wexinc.com
Life and AD&D Voluntary Life and AD&D Voluntary Short-term Disability Voluntary Accident Voluntary Critical Illness Voluntary Hospital Indemnity	BCBSIL	800-367-6401	www.bcbsil.com

If you have questions, please contact one of our Benefits staff members:

Manager of Client Services:

Julie Stigerwalt, 630-468-6525, julie.stigerwalt@bbrown.com

Senior Account Executive:

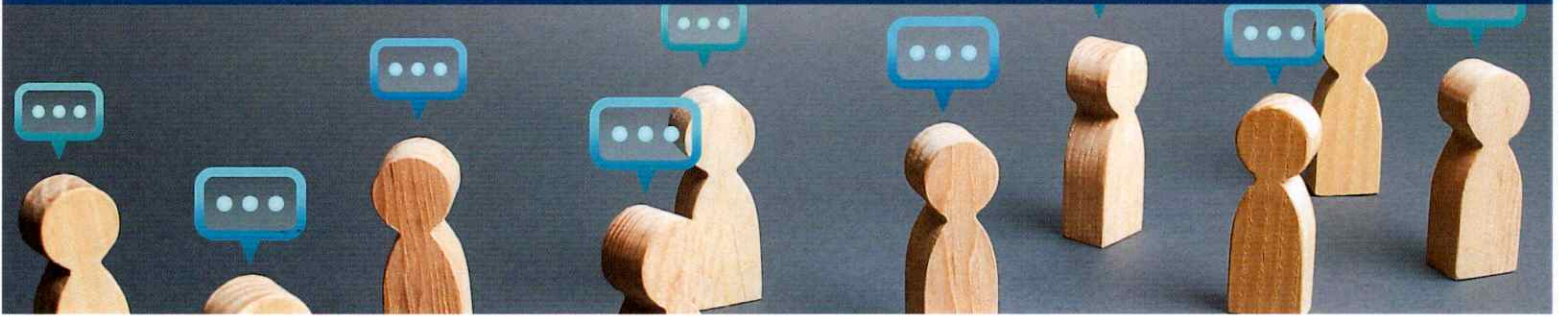
Bridgette Stewart, 630-468-6528, bridgette.stewart@bbrown.com

Employee Benefits Consultant:

Peyton Wyatt, 630-468-6558, peyton.wyatt@bbrown.com

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have questions about your Guide, contact

Employee Benefits Terminology



Health Care Benefits: Health Care Benefits provide preventive and protective coverage for medical, dental, vision, and prescription drugs for employees and their qualified dependents.

Medical care plans provide services or payments for services rendered in the hospital or by a qualified medical care provider.

BALANCE BILLING: When out-of-network providers bill for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in-network provider cannot balance bill you for the covered services.

BENEFICIARY: A designated person who is the recipient of proceeds from an insurance policy.

BIOMETRIC SCREENING: Usually a series of Body Mass Index (BMI) measurements and blood tests (e.g. pressure, cholesterol, and glucose) used to gauge an individual's overall health.

COINSURANCE: The percentage the plan or you pay for a covered service or supply. For example, the plan may pay 80 percent while you pay 20 percent.

COPAYMENT (COPAY): A copay is a flat-dollar amount you pay for specific covered services upon each visit to the provider. It is not impacted by the plan deductible, coinsurance, or out-of-pocket maximum.

DEDUCTIBLE: The amount you pay each year before the plan begins to pay coinsurance.

DEPENDENT: Relative of an employee who may be eligible for benefits' coverage if they meet certain criteria. Many benefits plans offer coverage to spouses, domestic/civil union partners, and children up to age 26 who are totally or substantially reliant on their parents for support, thereby defined as "dependent children."

ELIGIBLE EXPENSE: This is the amount on which payment is based for covered medical services; may also be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

ELIMINATION PERIOD: The period of time before you're eligible to receive benefits. Also known as the "waiting period."

EMPLOYEE CONTRIBUTION: The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

EVIDENCE OF INSURABILITY (EOI): The documentation of the good health condition of the insurance beneficiary and his/her dependent's health in order to be approved for coverage. It is

only required in certain circumstances.

EXPLANATION OF BENEFITS (EOB): After you receive medical services, your insurance will provide you with an EOB. It will outline details regarding how your insurance processed your medical claim, including what portion of the charges your insurance paid and what portion, if any, you are responsible for paying.

FLEXIBLE SPENDING ACCOUNT (FSA): An FSA is a tax-advantaged account that lets you put money aside on a pre-tax basis to pay for a wide range of health and/or dependent care expenses (as defined by the IRS) not covered by your plan that you incur during the plan year.

Unlike the HSA, any unused funds remaining after the plan year ends will be forfeited.

FORMULARY: A medical plan's formulary is a preferred brand-name drug list of the most cost-effective outcome-based drugs. You pay less when using a drug on the plan's formulary list.

HEALTH SAVINGS ACCOUNT (HSA): An HSA is a tax-advantaged savings account for high-deductible health plan (HDHP) participants that lets you put money aside on a pre-tax basis to pay for a wide range of health care expenses (as defined by the IRS) not covered by your plan. Unused money remaining in the account at the end of the plan year rolls over to be used the next year. Please refer to IRS Publications 502 and 969 for complete details on eligible expenses.

HSA CONTRIBUTION: This refers to a contribution, or "deposit," an employee may make to his/her HSA or a deposit made by the company to the HSA of an employee participating in the HDHP.

HIGH-DEDUCTIBLE HEALTH PLAN: A plan that provides competitive health insurance along with a tax-advantaged health savings account (HSA) that lets you decide how to spend your health care dollars. Essentially, you pay a lower premium in exchange for a higher deductible, much like car insurance.

HIPAA: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: HIPAA is a legal requirement that regulates how organizations must handle Protected Health Information (PHI).

Employee Benefits Terminology

IN- AND OUT-OF-NETWORK PROVIDERS: The facilities, providers, and suppliers a health insurance carrier contracts with to provide medical services at a pre-negotiated discount. You generally pay less out of pocket when you use in-network providers. Benefit plans develop networks by contracting with doctors, hospitals, labs, etc., who have agreed to provide health care services to members at negotiated rates. You generally pay less out-of-pocket when you use in-network providers.

INSURED: Person(s) covered under the medical plan to receive treatment and services. Includes primary insured (usually the employee) and their designated dependents.

INSURER: The company that underwrites and assumes the insurance risk for your medical plan. Also known as "insurance carrier."

MAXIMUM DOLLAR LIMIT: The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while the insured is enrolled in the health plan. Plans can have a yearly or lifetime maximum dollar limit. The most typical maximum limit is a lifetime amount of \$1 million per individual.

MEDICALLY NECESSARY: Medical services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine and are covered under your medical plan.

OUT-OF-POCKET MAXIMUM: The maximum amount you will pay out of pocket for covered medical expenses per calendar year, including your deductible. After your share of covered expenses reaches this annual limit, the plan pays 100% for eligible network services and supplies for the remainder of the calendar year.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN: A type of health plan that contracts with doctors, hospitals, labs, and other health care providers to create a network of participating providers. You generally pay less when you use providers that belong to the PPO network. You may use providers that fall outside of the plan's network at an additional cost. This type of plan typically has higher premiums and a lower deductible than a high-deductible health plan (HDHP).

PREMIUM: The contracted amount that must be paid for a health insurance plan by covered employees, by their employer, or is shared by both. A covered employee's share of the annual premium is generally paid periodically, such as bi-weekly or monthly, and deducted from his or her paycheck.

PREAUTHORIZATION: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called prior authorization, prior approval or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM: The maximum amount you will pay out of pocket for covered prescription drug expenses per calendar year. After your share of covered prescription drug expenses reaches this annual limit, the plan pays 100 percent for eligible prescription drugs for the remainder of the calendar year. The prescription drug out-of-

pocket maximum is separate from the medical out-of-pocket maximum.

PRESCRIPTION DRUG PLANS: Provide coverage for outpatient prescription drugs. Prescription drugs dispensed during a hospital stay are covered as hospital miscellaneous charges.

Name-brand drugs — These are drugs that once were or still are, under patents.

Generic drugs — These are drugs that are not under patent. Once a drug's patent has expired, some plans provide more generous coverage for same-formula generic drugs than for name-brand drugs. The practice is adopted as a cost-containment measure.

Mail-order drugs — These are drugs that can be ordered through the mail. As a cost-containment measure, some plans use mail-order

PRE-TAX DEDUCTION: Payments deducted from your gross pay before Medicare, Federal, and State taxes are calculated, thus reducing your taxable wages and tax liability.

PRIMARY CARE PHYSICIAN (PCP): A physician who directly provides or coordinates a wide range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners, OB/ GYNs, and Pediatricians. The opposite of a specialist.

PROVIDER: A physician, healthcare professional or healthcare facility, certified or accredited as required by state law..and mentally fit.

QUALIFYING LIFE EVENT (QLE): A change in your life that allows you to make changes to your benefits' coverage outside of the annual open enrollment period. These changes include a change in marital status (marriage, divorce, death of spouse), a change in the number of eligible children (birth, adoption, death, aging-out), and a change in a family member's benefits eligibility under another plan (losing a job, Medicare or Medicaid eligibility, etc.).

REASONABLE AND CUSTOMARY (R&C) CHARGES: The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount sometimes is used to determine the allowed amount.

SPECIALIST: A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The opposite of a Primary Care Physician (PCP). For example, a Dermatologist is considered a specialist.

SUMMARY PLAN DESCRIPTION (SPD): An important document that tells plan participants what the plan provides and how it works.

WELLNESS: Wellness refers to a healthy state of being. Many employers have wellness programs that encourage and sometimes incentivize employees to become more physically and mentally fit.

Disclaimer

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.



Village of Villa Park

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This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

