2025

Employee Benefits Overview

D155

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EMPLOYEE BENEFITS

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Notices at the end of this guide for more details.

D155 Employee Benefits

At Community High School District 155, we believe that you, our employees, are our most important asset. Helping you and your family achieve and maintain good health—physical, emotional and financial—is the reason Community High School District 155 offers you this benefits program.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your benefit plan booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid. You can view these documents on our benefit Touchpoints portal, **https://district155.touchpointsonline.com**.

A list of plan contacts is provided at the back of this summary.

The benefits in this summary are effective:

January 1, 2025 - December 31, 2025

Eligibility

Who Is Eligible?

In general, certified employees (teachers/administrators) working 20 or more hours per week and non-certified employees working 30 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including same-sex spouse).
- Your domestic partner, where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Up to the age of 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Who Is Not Eligible?

Family members who are not eligible for coverage include (but are not limited to):

- Spouses who have coverage available at his/her place of work. Refer to the Spouse Insurance Reimbursement section of this guide for details.
- Parents, grandparents and siblings.
- Certified employees who work less than 20 hours per week and non-certified employees who work less than 30 hours per week.

When Can I Enroll?

Coverage for new certified employees begins on the 1st of the month following the first day of work. Coverage for new non-certified employees begins on the 1st of the month following 30 days from the first day of work.

After that, Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Changes Permitted During the Year

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualifying life event or qualify for "special enrollment." Qualifying life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Notify Marnie Lalor **within 30 days** if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment.

Medical Benefits

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

District 155 gives you a **choice of 3 Aetna plans** that you can select from to best suit your medical needs. Please note that the HMO Plan requires the selection of a Primary Care Physician (PCP) and referrals for specialist visits and specialty care. Please note plan changes bolded below:

Plan Name:	**HMO Plan**	**PPO Plan**	
Network:	Aetna Select	Choice POS II	
Benefits	In Network Only	In-Network	Out-Of-Network
Annual Deductible	$1,500 per individual $3,000 family limit	$1,500 per individual (combined in / out) $3,000 family limit (combined in / out)	
Annual Out-of-Pocket Maximum	$1,500 per individual $3,000 family limit	$3,500 per individual $7,000 family limit	$4,100 per individual $8,200 family limit
Coinsurance	Plan pays 100% after applicable copay or deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Office Visit			
Primary Provider	$40 copay then plan pays 100%	$40 copay then plan pays 100%	Plan pays 60% after deductible
Specialist	$60 copay then plan pays 100% (Referral is required)	$60 copay then plan pays 100%	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 100%	Not covered
Diagnostics (X-rays, blood work)	$40 / $60 copay then plan pays 100%	$40 / $60 copay then plan pays 100%	Plan pays 60% after deductible
Imaging (CT/PET scans, MRIs)	$40 / $60 copay then plan pays 100%	$40 / $60 copay then plan pays 100%	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Surgery	$200 copay then plan pays 100%	Plan pays 80% after deductible	Plan pays 50% after deductible
Urgent Care	$40 copay then plan pays 100% (Must be affiliated with the medical group)	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	$200 copay then plan pays 100% (copay waived if admitted to hospital)	$200 copay then plan pays 80% (copay waived if admitted to hospital)	

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Medical Benefits, continued

Plan Name:	High Deductible / HSA Compatible PPO Plan*	
Network:	Choice POS II	
Benefits	In-Network	Out-Of-Network
Annual Deductible	**$3,300 per individual** **$6,600 family limit**	**$6,600 per individual** **$13,200 family limit**
Annual Out-of-Pocket Max	$5,400 per individual $10,800 family limit	$10,800 per individual $21,600 family limit
Office Visit		
Primary Provider	Plan pays 90% after deductible	Plan pays 70% after deductible
Specialist	Plan pays 90% after deductible	Plan pays 70% after deductible
Preventive Services	Plan pays 100%	Plan pays 70% after deductible
Diagnostics (X-rays, blood work)	Plan pays 90% after deductible	Plan pays 70% after deductible
Imaging (CT/PET scans, MRIs)	Plan pays 90% after deductible	Plan pays 70% after deductible
Inpatient Hospitalization	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 70% after deductible
Urgent Care	Plan pays 90% after deductible	Plan pays 70% after deductible
Emergency Room	Plan pays 90% after deductible	Plan pays 90% after deductible

* For employees who enroll in the High Deductible HSA Compatible PPO for plan year 2025, District 155 will make a Health Savings Account contribution of $1,825 for Single coverage, $2,737.50 for Single + Spouse or Single + Child(ren) coverage, and $3,650 for Family coverage. This annual calendar year HSA contribution will be prorated for employees who start insurance mid-year.

Accident and Critical Illness coverage will be provided at no cost to those who elect the High Deductible HSA Compatible PPO. This coverage will be at the same coverage tier you elect for the medical insurance, including those dependents covered under the Spousal Parity Insurance Reimbursement Plan.

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Medical Benefits, continued

Member Website

The Aetna Health℠ app and Aetna® member website have personalized tools that will make your plan easier to use. Go to Aetna.com to create an account and login to your member website. Get the Aetna Health app by texting "GETAPP" to 90156 for a link to download the app and create an account. Self-service tools available include:

- Check claims status and claims history
- View or print Explanation of Benefits
- Order or print a replacement ID card
- Check plan coverage details and prescription drug benefit information

Provider Finder

Use the Aetna "DocFind" tool to locate a network doctor, hospital, or other health care provider. Visit www.docfind.com and sign in to search for providers in your network or select your network and search as a guest.

Pre-Authorization

Preauthorization is a process used to determine whether a medical service meets the requirements for health plan coverage. You need to have preauthorization for some types of medical care like:

- Hospital stays
- High-cost specialty drugs
- Some services you get outside a hospital

Your network provider will usually take care of preauthorization. To be sure, call Aetna Concierge Customer Service before your service.

Away From Home Coverage

Be sure to register your coverage on Aetna's mobile app and always Carry your member ID card with you at all times, especially when you're traveling. If you have a life-threatening injury or illness when you're traveling, go to the nearest hospital. Please note that if the hospital is out of network, your costs may be higher. If you have questions before getting care, call the Aetna members Concierge line.

HMO – How It Works

While only offering in-network coverage, the HMO plan from Aetna does require you to select a Primary Care Physician (PCP) who will manage and coordinate all of your health care services. Always contact your PCP first for any care you need. Your PCP will provide you with a referral to a specialist if you need to see one. Make sure the doctors and hospitals you want to use are all in the Aetna Select network.

HMO Away From Home Care

Unlike traditional HMO plans, the Aetna HMO network maintains a nationwide presence, and has contracts with prominent providers in many Urban populations. If you or a dependent are traveling for an extended period, or are temporarily living away from home, you can use the Aetna DocFind application to search for providers anywhere in the nation.

CVS Health Hub

Your Aetna plan gives you access to convenient, local care at MinuteClinic at no cost to you. It's available when you need it, including nights and weekends. Get the care you deserve — without the out-of-pocket costs.

MinuteClinic is a walk-in clinic located inside select CVS Pharmacy and Target stores, treating a variety of illnesses, injuries, and conditions, such as Allergies, Ear Infections, Flu like symptoms and more.

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans. There are no benefit changes for 2025.

Plan Name:	HMO Plan	PPO Plan	
Drug List:	Standard	Standard	
Benefits	In-Network	In-Network	Out-Of-Network
Annual Deductible	$0	$0	$0
Annual Out-of-Pocket Limit	$1,000 per individual $2,000 per family	$4,850 per individual $9,700 per family	
Retail Pharmacy			
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 100%	Not covered
Preferred Brand	$60 copay then plan pays 100%	$60 copay then plan pays 100%	Not covered
Non-preferred Brand	$100 copay then plan pays 100%	$100 copay then plan pays 100%	Not covered
Specialty	$150 copay then plan pays 100%	$150 copay then plan pays 100%	Not covered
Supply Limit	34 days	34 days	Not applicable
Mail Order			
Generic	$20 copay then plan pays 100%	$20 copay then plan pays 100%	Not covered
Preferred Brand	$120 copay then plan pays 100%	$120 copay then plan pays 100%	Not covered
Non-preferred Brand	$200 copay then plan pays 100%	$200 copay then plan pays 100%	Not covered
Supply Limit	90 days	90 days	Not applicable

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Prescription Drugs, continued

Plan Name:	High Deductible / HSA Compatible PPO Plan	
Drug List:	Standard	
Benefits	In-Network	Out-Of-Network
Annual Deductible	Medical deductible must be met first before you pay applicable Rx copays.	
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	
Pharmacy		
Generic	$10 copay after deductible then plan pays 100%	Not covered
Preferred Brand	$25 copay after deductible then plan pays 100%	Not covered
Non-preferred Brand	$50 copay after deductible then plan pays 100%	Not covered
Supply Limit	34 days	Not applicable
Mail Order		
Generic	$20 copay after deductible then plan pays 100%	Not covered
Preferred Brand	$50 copay after deductible then plan pays 100%	Not covered
Non-preferred Brand	$100 copay after deductible then plan pays 100%	Not covered
Supply Limit	90 days	Not applicable

The prescription drug list shows you the drugs covered under the plan. The drugs on the list are split into levels, or tiers. You can use the list to see what tier your medicine falls under and how much you will pay for drugs in each tier. You can find your drug list by visiting www.caremark.com.

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Prescription Drugs, continued

Member Pays the Difference

When you fill a prescription for a covered brand name drug when a generic equivalent is available, you may pay more. You will pay the copay/coinsurance amount *plus* the difference in cost between the brand drug and its generic equivalent. This may apply even if your doctor writes “do not substitute” on your prescription. A generic equivalent is made with the same active ingredient(s) at the same dosage as the brand drug.

Specialty Drugs

Specialty drugs are those used to treat rare or less common serious or chronic conditions. Examples are hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis. These drugs may be given by infusion (intravenously), injection, taken by mouth or some other way. Your plan requires that you obtain your self-administered specialty drugs through CVS Caremark Specialty Pharmacy. Not using this pharmacy will result in you paying higher out-of-pocket costs.

PrudentRx Program

PrudentRx is an innovative program allowing members taking specialty medications to pay $0 out of pocket for specialty medications. PrudentRx coordinates with drug manufacturers’ copay assistance cards to lower costs for members. Everyone taking a specialty drug will be automatically enrolled, but you may opt out. If you opt out, there will be costs associated with your prescriptions. There are also additional guidelines based on the health plan you are enrolled in. Contact CVS Caremark with questions, or call PrudentRx at 800-578-4403.

Step Therapy

The step therapy program requires that you have a prescription history for a "first-line" medication before your benefit plan will cover a "second-line" drug. A "first-line" drug is recognized as safe and works well in treating a specific medical condition, as well as being a cost-effective treatment option. A "second-line" drug is a less-preferred or likely a more costly treatment option. If you and your doctor decide that a first-line drug is not right for you or is not as good in treating your condition, your doctor should submit a prior authorization request for coverage of the other drug.

Prior Authorization (PA)

Certain drugs may require pre-approval, called prior authorization. Your doctor will need to request prior authorization through Aetna in order for you to get benefits for these drugs. If you are taking, or prescribed, a drug that is newly introduced to the market on or after October 1, 2015, you may need to have your doctor submit a prior authorization request in order to get benefits for such drugs.

If you have any questions about the step therapy or prior authorization programs, call the number on the back of your ID card.

Maintenance Choice

Maintenance Choice helps keep medications you take regularly, such as asthma or high blood pressure, affordable with 90-day supplies. Starting filling your maintenance medications at any CVS Pharmacy or through the CVS Caremark Mail Service. You will have two 30-day grace fills before the mandatory transition will take place. If you fill with 30-day supplies or at another pharmacy, they won’t be covered and you ‘ll pay the entire cost.

Health & Wellness Programs

Aetna offers several wellness programs to supplement our plans. These programs are available to employees enrolled in our medical plans.

24/7 Nurse Line

With the 24-Hour Nurse Line, you can speak to a registered nurse whenever you need to. Plus —

- It's toll-free.
- You can call as many times as you need, at no extra cost.
- Your covered family members can use it, too.

The 24-Hour Nurse Line can possibly prevent an unneeded trip to the emergency room (ER). Plus, you'll be able to make smarter health decisions using reliable information you can trust — and it's only a phone call or click away. Go to Aetna.com to create an account and log in to your member website to visit the 24-Hour Nurse Line page online.

Women's and Family Health Pregnancy and Parenting Support

Having a baby is a special time in your life, and you deserve plenty of support. The Aetna Maternity Program is here to help you have a successful pregnancy. Once you are a member, this no-cost online resource is available throughout your maternity journey. Whether you are planning for baby, already pregnant or post-delivery, it is personalized for you. Sign up for the program on the Aetna member website.

Going Abroad?

Of course, emergencies don't wait for the right time or place. Aetna covers emergency inpatient hospital care when medically necessary, around the world.

If you need help and are outside the U.S., call (855) 888-9046 (TTY: 711) or (959) 230-8220 (TTY: 711). Ask for the Aetna Special Case Precertification Unit when you call, and they will help to arrange treatment or air ambulance services through a participating provider

Services must be provided in response to an emergency that cannot wait until you return to be considered for coverage. You will be responsible for paying for the services at the time they are rendered and submitting an itemized bill and claim form for reimbursement.

ChooseHealthy® Program Discounts

You can receive the following additional discounts and perks when you register your coverage at Aetna.com. These additional benefits are available through the ChooseHealthy Program, provided by ChooseHealthy, inc.:

Save on gym memberships, health coaching, fitness gear and nutrition products that support a healthy lifestyle. You get access to local and national discounts on brands you know. Savings also available for wearable fitness devices, yoga and meditation classes and Group Fitness on Demand.

With Hearing Care Solutions, you get discounts on a large choice of hearing aids and a three-year supply of batteries, after which, you can join a discount battery mail-order program. You can also receive free in-office service of hearing aids for one year and free routine cleanings and battery door replacements for one year after purchase from the original provider.

Discounts on oral health care products are provided so you can keep your mouth as healthy as possible. You can save on teeth whitening, electronic toothbrushes, Z Sonic™ toothbrushes, replacement brush heads and various oral health care kits.

Receive additional vision service discounts on designer frames, prescription lenses, non-disposable contact lenses and more. You can visit many doctors in private practice. Plus, national chains like LensCrafters, Target Optical and Pearle Vision

Healthcare Consumerism

We encourage our employees to take an active role in their benefits management by making educated decisions and taking full advantage of the programs we offer. Remember, you can help keep your own costs down! Below are some tips to help you become a better healthcare consumer.

HSA Compatible PPO Medical Plan

The Aetna HSA Compatible PPO plan is a consumer driven health care plan, also known as a High Deductible Health Plan (HDHP). Consumer driven health plans or HDHPs encourage you to be a savvy consumer of your medical dollars. Just as you would price shop for other products and services, you should do so for prescription and healthcare services. It is designed to give you more choice over how your benefit dollars are spent and the freedom to select your doctors.

This plan includes the following elements:

- ✓ Traditional PPO medical plan with a higher deductible
- ✓ You can fund a Health Savings Account (HSA) with pre-tax dollars
- ✓ 100% coverage for preventive care services
- ✓ Employer contribution from District 155 towards your Health Savings Account (HSA)

In-Network Care

Your copay or coinsurance will be lowest when you go to an in-network provider. If you go to an out-of-network provider, they may balance bill you for additional charges if their fees are more than the carrier's maximum allowed amount. You will be responsible for covering this out-of-pocket expense.

Emergency Room vs. Urgent Care Clinics

ER visits should be used in a true emergency - such as any situation of a life-threatening condition, chest pain, shortness of breath, serious bodily injury, severe abdominal pain, loss of consciousness. Otherwise, for non-emergencies, call your doctor, your nurse line, or go to an urgent care clinic for basic illness/injury, stitches/sutures, or fever. This will save you a lot of money and time.

Review Your Medical Bills and Explanation of Benefits (EOB)

Make sure you always check your medical bills and explanation of benefits for accuracy. Medical billing is complicated, and mistakes can easily happen. Make sure to contact your provider and/or carrier if you believe there may be an error.

Prescriptions

If you need a medication, you can save money by asking your doctor if there are generics or generic alternatives for your specific medication. Generics are safe and effective. They are the equivalent of brand-name drugs and usually cost 30% to 60% less than brand drugs. You can also use the mail order program through CVS Caremark pharmacies which provides three times the quantity of a retail prescription at only twice the cost. Register online at **caremark.com**.

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Healthcare Consumerism, continued

WHAT PREVENTIVE CARE SERVICES SHOULD YOU BE GETTING?

Children:

- Well-baby care
- Annual physicals
- Immunizations
- Flu shots
- Medical/family history and physical exams
- Blood pressure checks
- Vision screening

Females:

- Pap tests
- Mammograms
- Annual physicals
- FDA approved contraception
- Immunizations
- Flu shots
- Colonoscopy
- Blood pressure checks

Males:

- Colonoscopy
- Prostate cancer screening
- Annual physicals
- Immunizations
- Flu shots
- Blood pressure checks
- Cholesterol (total and HDL)

Preventive Care

Our plans cover preventive visits at no cost. This is a Healthcare Reform requirement. Preventive visits can include annual exams, immunizations, wellness visits, screenings, and well-woman exams. Going in for your regular physical exams is not only free, but it is also the single best way to keep your medical costs down as they can detect health issues early, when they are generally less complicated to treat. Refer to your plan benefit summary for a complete list of covered services.

Preventive or Diagnostic Care?

Did you know there are tests that can help you stay healthy, catch any problems early on and even save your life? They're called preventive care because they can help prevent some health problems. They're different from diagnostic care, which is when you have symptoms of a health problem and the doctor wants to find out why.

In-network preventive care is paid for by your medical benefits with us, but you'll have to pay part of the cost of diagnostic care, depending on your specific plan.

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes and heart disease. We offer you the following dental plan through Delta Dental.

	PPO Dental Plan		
	In-Network	In-Network	Out-Of-Network
Network	**PPO**	**Premier**	
Calendar Year Deductible	$0 per individual $0 per family	$0 per individual $0 per family	$0 per individual $0 per family
Annual Plan Maximum	$1,750		
Diagnostic and Preventive Services Routine Oral Exams, Bitewing X-rays, Fluoride Treatments, Routine Cleanings - 2 per Calendar Year	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services Periodontal Maintenance, Fillings, Root Canal Treatment	Plan pays 100%	Plan pays 100%	Plan pays 100%
Major Services Crowns, Bridges, Dentures, Implants	Plan pays 50%	Plan pays 50%	Plan pays 50%
Orthodontic Services (to age 26) and Adults Orthodontia Lifetime Maximum	Plan pays 50% $1,500		

To find an in-network dentist visit **www.deltadentalil.com** and click on find a provider.

Save the most money by using a Delta Dental PPO network dentist. PPO providers accept payment based on the lesser of their usual fee or Delta Dental's allowed PPO fee. PPO providers cannot charge you for costs exceeding the PPO fee.

Delta Dental Premier Network dentists accept payment based on the lesser of their usual fee or Delta Dental's maximum plan allowance (MPA). Premier providers may not charge you for costs exceeding the MPA. Out-Of-Network providers accept payment based on the lesser of their usual fee or the MPA. They can charge you for costs exceeding the MPA.

Example of a cost of a crown:

If you use a PPO Network Provider
PPO Allowed Fee: $605.00
Member pays 50%: $302.50

If you use a Premier Network Provider
Delta Dental MPA Fee: $901.00
Member pays 50%: $450.50

If you use an Out-Of-Network Provider
Dentist Billed Fees: $1074.00
Member pays 50%: $623.50

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. When you enroll in the Vision plan, you are provided with the following coverage through VSP.

	Vision Plan	
	In-Network	**Out-Of-Network**
Network	**VSP Signature**	
Examination		
Benefit	$0 copay then plan pays 100%	Reimbursed up to $25
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Materials	$0 copay then plan pays 100%	See schedule below
Eyeglass Lenses		
Single Vision Lens	Plan pays 100% of basic lens	Reimbursed up to $30
Bifocal Lens	Plan pays 100% of basic lens	Reimbursed up to $35
Trifocal Lens	Plan pays 100% of basic lens	Reimbursed up to $45
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Frames		
Benefit	$150 allowance, then plan pays 20% of the remaining balance	Reimbursed up to $45
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Contacts (Instead of glasses)		
Medically Necessary	Paid in full	Reimbursed up to $150
Elective	$150 allowance, copay up to $60	Reimbursed up to $100
Frequency	1 x every 12 months from last date of service	In-network limitations apply

To find an in-network eye doctor visit **www.VSP.com**.

Life & Disability Insurance

If you have loved ones who depend on your income for support, having life and disability insurance can help protect your family's financial security and pay for large expenses such as housing, education, and living expenses in the event that your income is lost. Coverage is provided by The Standard.

Basic Life/AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. Accidental Death & Dismemberment (AD&D) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, hearing, or if you die in an accident. The cost of coverage is paid in full by District 155.

Basic Life/AD&D Amount	2 x covered annual earnings up to a maximum of $400,000

Voluntary Life/AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. If you apply for this coverage, you pay the full cost.

Employee Voluntary Life/AD&D Amount	Increments of $10,000 up to $500,000
Guarantee Issue	$150,000
Spouse Voluntary Life /AD&D Amount	Increments of $5,000 up to the lesser of $250,000 or 100% of employee amount
Guarantee Issue	$25,000
Child(ren) Voluntary Life/AD&D Amount	Birth through age 25: Increments of $2,000 up to $10,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Age Reduction: An age reduction applies to life and AD&D insurance. The amount of basic life coverage reduces to 50% of the original amount when you reach age 70. The amount of voluntary life coverage reduces to 65% of the original amount at age 65, to 50% at age 70, and to 35% at age 75.

Guarantee Issue

Guarantee issue is available to new employees. If you select a coverage amount above the guaranteed issue limit, you will need to submit an Evidence of Insurability (EOI) form with additional information about your health in order for the insurance company to approve this higher amount of coverage. For late entrants and during the annual open enrollment, all amounts will require evidence of insurability.

Long-Term Disability

Long-Term Disability (LTD) is available to certified employees. LTD coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. If you qualify, Long-term Disability coverage is provided by District 155 at no cost to you.

Monthly Benefit Amount	Plan pays 66 2/3% of covered monthly earnings
Maximum Monthly Benefit	$11,000
Benefits Begin After:	180 days of disability
Maximum Payment Period	SSNRA

Additional Benefits

We are pleased to provide Critical Illness and Accident coverage at no cost to you if you enroll in the High Deductible HSA-Compatible PPO medical plan. Even with medical insurance, illnesses and injuries can leave you with hefty bills.

Critical Illness

Critical Illness Insurance can help fill that financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. The benefit can be used however you see fit—to pay for your medical bills, childcare, or meals.

This plan pays a $50 health maintenance screening benefit once per calendar year when you or your dependents receive one of 20 covered wellness screenings, including a mammogram, complete blood count, lipid panel or colonoscopy. Submit a health maintenance screening claim form to redeem the benefit.

Employee: Benefit Amount	**$10,000**
Spouse: Benefit Amount	**$10,000**
Child: Benefit Amount	**$2,500**
Wellness Benefit	**$50 per Insured**
Covered Conditions	**Covered at 100%:** Heart Attack Stroke Cancer (invasive) Coma Kidney Failure Loss of Sight Major Organ Failure Occupational HIV or hepatitis **Covered at 25%:** Carcinoma in Situ Severe Coronary Artery Disease with Recommendation for Bypass Surgery

Accident

Accident Insurance includes benefits for a wide range of injuries such as fractures, dislocations, burns, ER or urgent care visit, and physical therapy. The amount of money you receive depends on the type and severity of your injury. You can use the benefit however you see fit—to pay for your medical bills, childcare, or meals.

This plan pays a $50 health maintenance screening benefit once per calendar year when you or your dependents receive one of 20 covered wellness screenings, including mammograms, complete blood counts, lipid panels and colonoscopies. Submit a health maintenance screening claim form to redeem the benefit.

Ambulance	**Air transport: $800** **Ground transport: $300**
Emergency Room	**$150**
Urgent Care Visit	**$50**
Hospital Admission / Confinement	**$1,000 per admission (once per covered accident) / $200 per day (maximum 365 days per covered accident)**
Physical Therapy	**$50 per day (maximum 3 visits per covered accident, 1 per day)**
Laceration	**Schedule up to $500**
Dislocations	**Schedule up to $5,000**
Fractures	**Schedule up to $8,000**
Wellness Benefit	**$50 per Insured**

Health Savings Account (HSA)

Do you want to save money on taxes? A Health Savings Account (HSA) is a tax-advantaged, portable (you own it!) savings account that is offered if you enroll in the High Deductible HSA-compatible PPO Plan through Aetna. To learn more about how an HSA works, click **here**. 

District 155 contributes, and you may also contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Plus, any money that you don't spend grows year after year and can be used in the future, even after you retire.

2025 Account Contributions

	District 155 Contributes	You May Contribute*
	All Employees	**Teachers/Administrators/Support Staff**
Employee	$1,825	Up to $2,475
Employee + Spouse	$2,737.50	Up to $5,812.50
Employee & Child(ren)	$2,737.50	Up to $5,812.50
Employee + Family	$3,650	Up to $4,900

***Contribution limits: The IRS has set limits on the total amount you can contribute to a Health Savings Account each calendar year. In 2025, the limit is $4,300 for an individual and $8,550 for a family (including any employer contribution). If you're over 55, the IRS allows you to contribute an additional $1,000-this is called a "catch-up" contribution.**

Using Your Money

You can use the money in your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). For a full list of those expenses, go to irs.gov.

Eligible expenses include, but are not limited to:

- Co-pays, deductibles, coinsurance
- Prescriptions
- Dental expenses, including orthodontia
- Vision expenses, including Lasik

If you use HSA funds for non-qualified expenses before you are age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. If you use HSA funds for non-qualified expenses after age 65, you will owe income tax only.

Note: Make sure that you keep records of your receipts and any over-the-counter (OTC) prescriptions. You will need them to prove that you spent the money on qualified expenses if you are audited by the IRS.

Eligibility

You are **not** eligible to open or contribute to an HSA account if you are:

- Covered by a non-high deductible health plan
- Enrolled in a regular healthcare FSA (you or your spouse count)
- Covered under Medicare or Medicaid
- Claimed as a dependent on someone else's tax return

HSA Account Activation

HSA Bank is our sponsored HSA Trustee. You may use any bank or trustee you wish to use. Refer to the Touchpoints website on the Medical Plans page under the HSA plan documents for HSA Bank forms and additional information on opening an account.

Establishment of an HSA

The account is not considered established until funded. If funding your account via payroll deductions, consider the timing of the first payroll after opening the account.

Distributions from the account may not be taken for any services provided prior to the establishment of the account.

Flexible Spending Accounts (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. Group Administrators administers this program.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 1/1/25 and 12/31/25 and submitted for reimbursement no later than 3/31/26.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the District 155 health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- Please refer to the eligible expense listing at **www.fsastore.com**.

Healthcare FSA Account

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses may be incurred by you or your eligible dependents, as defined by the IRS. To learn more about how a healthcare FSA works, click **here**.

Visit also the Touchpoints website, **district155.touchpointsonline.com** for information about this plan. You may contribute up to $3,300 per year to your Healthcare FSA.

Eligible Expenses Include:

Any health-related medical treatment, medication, medical procedure, including flu shots, chiropractic care, acupuncture, Lasik eye surgery, eye exams, prescription sunglasses, physical therapy, durable medical equipment.

Ineligible Expenses Include:

Any cosmetic medical or dental care and treatments. Vitamins, nutritional supplements and food, minerals, herbs, insurance premiums, eligible services paid for but not yet received. Procedures such as massage therapy and weight loss programs.

Important Note:

IRS regulations prohibits participation in a Healthcare FSA when you are making contributions to a Health Savings Account (HSA). All participants in the Flexible Spending Accounts will receive a Debit card for immediate use.

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Flexible Spending Accounts, continued

Dependent Care FSA Account

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan.

Visit the **Touchpoints** website for more information about this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year or $2,500 if married and filing separately.

Dependent Care Flexible Spending Account (FSA) lets you pay for eligible expenses such as:

- Childcare
- Preschool
- Before and after school care
- Day camps

	Flexible Spending Account (FSA)	Dependent Care Flexible Spending Account (DCA)
Tax Advantage	**Tax-free as long as used for eligible expenses**	
Eligible Expenses	**Medical, Dental, Vision (see IRS publication 502)**	**Dependent care for eligible dependents that is necessary for you to work**
Maximum Deposits	**For 2025: $3,300**	**For 2025: $5,000 (Family)**
Availability of Funds	**1st day of the plan year**	**After your payroll deduction**
Portable after Termination of Employment	**No**	**No**

Note: If you use the dependent care FSA, the IRS will not allow you to claim a dependent care tax credit. Consult your tax advisor if you have questions about the federal tax credit.

Manage Your FSA Accounts Online

Once enrolled, you can manage your Healthcare and Dependent Care FSA Accounts on **wealthcareadmin.com** and select "Participant Login".

Your employee ID is your Social Security Number and you can skip the Employer ID box. If you have any questions about this website, call 800-323-1683 x297.

Other Programs

Employee Assistance Program

The confidential Employee Assistance Program (EAP) through Aetna can help you with things like mental health, chemical dependency, relationship issues, legal consultation, family care, financial counseling, and dependent care resources. Its designed specifically for educators and school employees, and best of all, it's free. The EAP is available to all immediate household members. Call (888) 866-4827 or go to www.resourcesforliving.com and login with Username: D155, Password: EAP.

- ✓ Unlimited free phone access 24/7
- ✓ In-person help for short-term issues
- ✓ Web access to articles and resources

Travel Assistance

Travel Assistance is available through The Standard and Generali Global Assistance (GGA) when you travel more than 100 miles from home or internationally. This program provides up-to-date intelligence about events around the world that could impact your health, safety and security while traveling and gives you access to a host of tools that help minimize the inconveniences associated with travel. Visit **standard.com/travel** to register using group ID: D2STDS and Code: 181002 or call 866-45-9188 for more information.

- ✓ Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- ✓ Help replacing prescription medication or lost corrective lenses and advancing funds for emergency medical payment
- ✓ Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- ✓ And more!

Telemedicine

Teladoc provides access to board certified physicians that can diagnose illness, recommend treatment and prescribe medications over the phone. Call 800-835-2362 or visit www.Teladoc.com/Aetna to schedule a physician consultation from home, work or when traveling. Quality medical care is available 24/7 and 365 days per year to diagnose and treat acute care illnesses such as:

- ✓ Allergies
- ✓ Ear Infections
- ✓ Insect Bites
- ✓ Sprains/Strains
- ✓ Sore Throat
- ✓ Minor Burns
- ✓ Certain Rashes
- ✓ Cold/Flu Symptoms
- ✓ Headaches/Migraines
- ✓ Sinus Infections
- ✓ Respiratory Infections

Spouse Insurance Reimbursement

District #155 does not allow spouses to be covered under our health insurance if he/she can get coverage at his/her place of work. The spouse insurance reimbursement plan may provide a subsidy for your spouse's health insurance premiums and/or claims.

This plan may reimburse in-network deductibles, coinsurance and copays based on District #155's in-network benefits. A copy of the Explanation of Benefits (EOB) from your spouse's insurance plan must accompany a claim form to be reimbursed. A copy of your spouse's employer's premium contributions, paystub for proof of insurance deduction and benefit highlight sheet will need to be submitted for a premium subsidy.

To be eligible for this health reimbursement plan you must have family coverage in force with a family medical deduction through District 155. All employees in this reimbursement plan must complete a Spousal Affidavit of Insurance Coverage. The spousal affidavit and claim form are available on our **Touchpoints** website.

Cost of Coverage

The amount that you pay for your coverage is outlined below.

Medical – Teachers & Support Staff

Your Cost per Paycheck (24 checks)	HMO	PPO	HDHP
Single Coverage	$88.07	$134.36	$45.50
Employee + Spouse	$409.24	$501.97	$353.77
Employee + Child or Children	$382.66	$471.25	$328.08
Family Coverage	$686.45	$825.73	$626.08

Medical – Top Step Teachers, Admin & Grandfathered

Your Cost per Paycheck (24 checks)	HMO	PPO	HDHP
Single Coverage	$88.07	$134.36	$45.50
Employee + Spouse	$268.47	$249.93	$45.50
Employee + Child or Children	$255.11	$238.09	$45.50
Family Coverage	$453.84	$593.12	$45.50

Medical – Spouse Works for District

Your Cost per Paycheck (24 checks)	HMO	PPO	HDHP
Employee + Spouse *	$176.14	$268.72	$91.00
Family Coverage *	$487.83	$627.14	$91.00

** For Dual Spouse Family Plans, the above "employee" portion will be collected from both spouses (each spouse charged half of the total rate)*

Spouses may not be enrolled on a District 155 insurance plan if they have access to insurance elsewhere. Employees who select a "Family" insurance plan will be eligible for the spousal insurance reimbursement plan. Single, Employee + Spouse, and Employee + Child plans are not eligible for spousal parity.

Note: Per paycheck amounts for employees who elect to receive 20 pays will be 20% higher than the amounts shown above in order to cover July and August insurance premiums when paychecks are not issued.

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Cost of Coverage

Dental – Teachers, Support & Admin

Your Cost per Paycheck (24 checks)	Dental Plan
Single Coverage	$0.00
Family Coverage	$25.95

Dental – Spouse Works for District

Your Cost per Paycheck (24 checks)	Dental Plan
Single Coverage	$0.00
Family Coverage	$0.00

Vision – Teachers, Support & Admin

Your Cost per Paycheck (24 checks)	Vision Plan
Single Coverage	$0.00
Family Coverage	$4.18

Vision – Spouse Works for District

Your Cost per Paycheck (24 checks)	Vision Plan
Single Coverage	$0.00
Family Coverage	$0.00

Note: Unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Marnie Lalor if your domestic partner is your tax dependent.

Note: Per paycheck amounts for employees who elect to receive 20 pays will be 20% higher than the amounts shown above in order to cover July and August insurance premiums when paychecks are not issued.

Contacts

Carrier Contacts

If you need to reach our plan providers, for issues with claims, billing, finding a provider, or anything else, below is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	aetna	(855) 824-4116	www.aetna.com	176675
Prescription Drugs	CVS caremark	(855) 344-0938	www.caremark.com	RX21GD
Dental	DELTA DENTAL	(800) 323-1743	www.deltadentalil.com	11377
Vision	vsp	(800) 877-7195	www.vsp.com	12001961
Life & Disability	The Standard	(800) 368-1135	www.standard.com	161307
Accident and Critical Illness	The Standard	(866) 851-5505	www.standard.com	161307
Travel Assistance	The Standard	(866) 455-9188	www.standard.com/travel	ID: D2STD Code: 181002
HSA	hsabank	(800) 357-6246	www.hsabank.com	
FSA	Group Administrators	(847) 519-1880	www.wealthcareadmin.com	
Spouse Insurance Reimbursement	Group Administrators	(847) 519-1880	www.groupadministrators.com	
Telemedicine	TELADOC	(800) 835-2362	www.teladoc.com/aetna	176675
Employee Assistance Program (EAP)	aetna	(888) 866-4827	www.resourcesforliving.com	ID: D155 Password: EAP

Contacts, continued

Company Contacts

If you need escalated assistance with one of these carriers, or have a benefit related question not specific to one of these carriers, you may contact:

Contact	Company	Name	Phone Number	Email
Benefits Coordinator	D155 INSPIRE. EMPOWER. NURTURE. Enter with promise. Leave with purpose.	Marnie Lalor	(815) 455-8500 ext. 1021	mlalor@d155.org
Broker	Alliant EMPLOYEE BENEFITS	Wendy Williams	(847) 444-2581	wendy.williams@alliant.com

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

Medical

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA or FSA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

Prescription Drugs

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the drug list may not be covered.

Dental

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex dental work such as crowns, bridges, dentures, inlays and onlays.

ANNUAL MAXIMUM – Once an individual has exhausted the amount listed for the annual maximum, the plan stops paying.

MAXIMUM PLAN ALLOWANCE- The amount that an in-network Dentist agrees to accept as full payment for covered procedures.

Important Plan Notices and Documents

Current Health Plan Notices

Notices are provided to plan participants on an annual basis and are available in the in the following sections of this Summary. The notices applicable to your health coverage include the following:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- HIPAA Notice of Privacy Practices
  Describes how health information about you may be used and disclosed.
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.
- Illinois Consumer Coverage Disclosure Act
  Requires employers to notify Illinois employees which of the Essential Health Benefits are covered under the group health plan.
- ACA Disclaimer
  Notifies you that the offer of coverage may disqualify you from government subsidies in an Exchange plan.
- Non-Discrimination and Accessibility Requirements Notice
  Notice that your employer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- The “No Surprises” Rule
  Notifies you of protection from surprise medical bills in situations where you can’t easily choose a provider in your network.

Cobra Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

Electronic copies of these documents and notices are available on our Touchpoints website **https://district155.touchpointsonline.com/**.

Medicare Part D Notice

Important Notice from District 155 About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with District 155 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. District 155 has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your District 155 coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Aetna is/are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your District 155 prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

You should also know that if you drop or lose your current coverage with District 155 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through District 155 changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2025
Name of Entity/Sender:	Community High School District 155
Contact (Position):	Marnie Lalor, Benefits Coordinator
Address:	1 S. Virginia Rd. Crystal Lake, IL 60014
Phone Number:	.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for District 155 describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your plan administrator at 815-455-8500 x1021.

Notice of Choice of Providers

The Community High School District 155 HMO Plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at www.aetna.com or at the phone number listed on the back of your ID card. For children under age 18, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at www.aetna.com or at the phone number listed on the back of your ID card.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance illustrated in the medical section of your benefit guide will apply. If you would like more information on WHCRA benefits, call Aetna at the phone number listed on the back of your ID card.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call Aetna at the phone number listed on the back of your ID card.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in District 155 health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in District 155 health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in District 155 health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

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

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2020)

Nondiscrimination and Accessibility Requirements Notice

District 155 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. District 155 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. District 155:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Human Resources. If you believe that District 155 has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-7733294171.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-7733294171.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 – 7733294171

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-7733294171번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-7733294171.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-7733294171.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-7733294171.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-7733294171.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-7733294171.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-7733294171 पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-7733294171.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-7733294171.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-7733294171.

The “No Surprises” Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

View a sample notice and consent form (PDF).

This applies to you if you’re a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income..

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Community High School District #155
Employer State of Situs:	Illinois
Name of Issuer:	Aetna
Plan Marketing Name:	Aetna Select HMO, Aetna Choice PPO, Aetna Choice HDHP
Plan Year:	January 1, 2025 – December 31, 2025

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes* (please refer to plan documents for exclusions)
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes* (please refer to plan documents for exclusions)
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes* (please refer to plan documents for exclusions)
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes* (please refer to plan documents for exclusions)
5	Hospice	Ambulatory	Pg. 28	Yes* (please refer to plan documents for exclusions)
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes* (please refer to plan documents for exclusions)
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes* (please refer to plan documents for exclusions)
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes* (please refer to plan documents for exclusions)
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes PPO/HDHP - as part of Home Health; *not covered on the HMO/OA
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes* (please refer to plan documents for exclusions)
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes* (please refer to plan documents for exclusions)
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes* (please refer to plan documents for exclusions)
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes* (please refer to plan documents for exclusions)
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes* (please refer to plan documents for exclusions)
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes* (please refer to plan documents for exclusions)
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes* (please refer to plan documents for exclusions)
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes* (please refer to plan documents for exclusions)
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes* (please refer to plan documents for exclusions)
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes* (please refer to plan documents for exclusions)

20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes* (please refer to plan documents for exclusions)
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes* (please refer to plan documents for exclusions)
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes* (please refer to plan documents for exclusions)
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes* (please refer to plan documents for exclusions)
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes* (please refer to plan documents for exclusions)
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes* (please refer to plan documents for exclusions)
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes* (please refer to plan documents for exclusions)
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes* (please refer to plan documents for exclusions)
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No - may be covered by a separate dental plan
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No - may be covered by a separate vision plan
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes* (please refer to plan documents for exclusions)
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes* (please refer to plan documents for exclusions)
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes* (please refer to plan documents for exclusions)
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes* (please refer to plan documents for exclusions)
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes* (please refer to plan documents for exclusions)
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes* (please refer to plan documents for exclusions)
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes* (please refer to plan documents for exclusions)
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes* (please refer to plan documents for exclusions)
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes* (please refer to plan documents for exclusions)
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes* (please refer to plan documents for exclusions)
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes* (please refer to plan documents for exclusions)
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes* (please refer to plan documents for limitations)
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes* (please refer to plan documents for exclusions)
Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.				

Notes

D155

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Alliant

EMPLOYEE BENEFITS