Community Unit School District 303

1949

2024

Benefit Guide

Table of Contents

Welcome To Your Employee Benefits! 3

Contacts 3

Eligibility & Enrollment 4

Employee Contributions 5

Medical Insurance 6

Dental Insurance 7

Vision Insurance 8

Flexible Spending Accounts (FSA) 9

Health Savings Account (HSA) 10

Basic Life/AD&D Insurance 11

Voluntary Life/AD&D Insurance 12

Employee Assistance Program 13

Telemedicine 14

Meds Your Way 15

Medical Member Resources 16

Benefit Terms 18

Important Disclosures & Notices 19

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Welcome To Your Employee Benefits!

We understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. Within this guide, you will find the highlights of the benefits offered by D303.

Open Enrollment for All Employees

CUSD 303 Annual Benefits Open Enrollment period will begin Wednesday, November 1st – Sunday, November 19th. During this time, everyone must enroll/re-enroll/waive coverage for 2024. Enrollment is done online through the Employee Access portal. If you are choosing the CDHP medical plan, you may participate in the Health Savings Account (HSA).

You may also elect to enroll or re-enroll in the Flexible Spending Account (FSA). Complete the online enrollment process and return all appropriate forms to Human Resources no later than November 19th. Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

New Employees

This is your chance to elect benefits and enroll yourself and your eligible dependents. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverages. If you take no action now, you will have no benefits and you will not have another chance to elect them until open enrollment—unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time. Enrollment is done online through the Employee Access Portal. Complete the online enrollment process and return all appropriate forms to Human Resources within 31 days from your initial start date.

As a new employee, you may elect additional Voluntary Life Insurance. This initial enrollment requires no Evidence of Insurability (EOI) for coverage less than guaranteed issue amounts. EOI is the insurance company's medical questionnaire and possible exam process.

Contacts

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE
Medical Insurance	BCBS of IL	PPO/CDHP – 800.828.3116 HMO – 800.892.2803	www.bcbsil.com
Dental Insurance	MetLife	800.942.0854	www.metlife.com
Vision Insurance	VSP	800.877.7195	www.vsp.com
Flexible Spending Account	Further	800.859.2144	www.hellofurther.com
Health Savings Account	Further	800.859.2144	www.hellofurther.com
Northwestern Medicine	EAP	888.933.1327	www.nm.org

Please note that all enrollment documents, plan documents, plan summaries and amendments, and benefit notices will be sent and available electronically via D303's website and email network.

Eligibility & Enrollment

Employee Eligibility

All full-time employees working 30 or more hours per week are eligible for benefits. If you are a new employee, you have 31 days from your initial start date to enroll in benefits. Your coverage will take effect on the first day of employment.

*These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact the Benefits Coordinator, for additional information.

Dependent Eligibility

- Medical/Vision, Dental: Employees enrolled in Medical/Vision and/or Dental coverages also have the option to enroll their Dependent Spouse and/or Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.
  - » If your dependent spouse is not employed full-time outside of D303 or is not eligible or covered for benefits under a plan provided by his or her employer, your spouse is eligible for benefits under the D303 Medical and Vision plan as primary.
  - » If your dependent spouse is a full-time employee outside of D303 and is eligible for benefits under a plan provided by his or her employer, your dependent spouse must elect those benefits or he/she will not be considered an eligible dependent for coverage under D303's Medical and Vision Plans. Once your dependent spouse has elected benefits through his/her employer, he/she can be enrolled in the D303 Medical and Vision plans as secondary.
  - » Spousal Affidavit form MUST be completed regardless of the reason you may be adding your spouse to the insurance. A new Spousal Affidavit form will be required at each open enrollment.
  - » Your dependent spouse is eligible for the D303 dental benefits regardless of employment status.
  - » If you are adding your spouse and/or children on to the plan for the first time, you will need to provide a copy of your marriage license and/or birth certificates to Human Resources.
- Other Coverages: Employees enrolled in Voluntary Life/AD&D coverage also have the option to enroll their Dependent Spouse and Dependent Children. It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or the Benefits Coordinator for more information.

Definition of "Eligible Dependents"

The below definitions refer to **Medical, Dental, and Vision Coverages**:

- The employee's legal spouse or civil union partner.
- The employee's dependent child(ren) under 26 years of age (under 30 years of age if eligible military veteran).
- Children age 26 and over who are physically or mentally disabled and dependent upon you for support.
- Grandchildren who are under your legal guardianship.

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully. To enroll, log in to Employee Access, go to My Benefits, and select Enrollment. Follow the instructions on the screen.

When to Enroll

Open enrollment begins on November 1st and runs through November 19th. The benefits you choose during open enrollment will become effective on January 1, 2024.

New hires have 31 days from your initial start date to enroll in benefits. The benefits you choose will be effective on the first day of employment with the District.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event.

Qualifying life events include:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer- sponsored plan.

Employee Contributions

MEDICAL COVERAGE	CDHP		PPO		HMOI	
	Per Pay	Per Month	Per Pay	Per Month	Per Pay	Per Month
Employee Only	$15.51	$31.02	$44.90	$89.80	$70.13	$140.26
Employee + Spouse	$66.68	$133.35	$130.33	$260.66	$179.00	$358.00
Employee + Child(ren)	$43.12	$86.25	$95.18	$190.36	$136.14	$272.28
Family	$125.95	$251.90	$235.75	$471.50	$325.82	$651.64

DENTAL COVERAGE	CDHP	
	Per Pay	Per Month
Employee Only	$17.59	$35.18
Family	$54.23	$108.46

VISION COVERAGE	Vision is not available as a stand-alone coverage. Must be enrolled in Medical.
Employee Only	100% Employer-Paid
Family	100% Employer-Paid

Please Note: Must select the same Vision Coverage as Medical Coverage

LIFE/AD&D COVERAGE	BASIC	TERM
Employee Only	100% Employer-Paid	100% Voluntary*
Employee + Spouse	N/A	100% Voluntary*
Employee + Child(ren)	N/A	100% Voluntary*
Family	N/A	100% Voluntary*

*See Staff Website for details.

- Deductions are taken per paycheck (twice per month). Employees who do not get paychecks during the summer months will have deductions for the summer months taken from their last pay of the school year.
- Tenured part-time teachers have separate rates. Please call the Benefits Coordinator if you need the rates for a part-time tenured position.

Medical Insurance

BlueCross BlueShield of Illinois

The District provides employees the option to purchase affordable medical coverage. The below plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider. For a complete list of your in-network and out-of-network benefits, please refer to your Medical Insurance Summary Plan Description, located on the staff website. Visit **www.bcbsil.com** to find an in-network provider.

MEDICAL COVERAGE HIGHLIGHTS	CDHP		PPO		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
ANNUAL DEDUCTIBLE					
Single	$2,000	$4,000	$500	$1,000	N/A
Single + 1	N/A	N/A	$1,000	$2,000	N/A
Family	$4,000	$8,000	$1,500	$3,000	N/A
COINSURANCE (percent paid after you reach your annual deductible)					
Plan Pays	80%	60%	80%	70%	100%
You Pay	20%	40%	20%	30%	0%
ANNUAL OUT-OF-POCKET MAXIMUM					
Single	$7,000	$14,000	$4,500	$9,000	$1,500
Single + 1	N/A	N/A	$9,000	$18,000	N/A
Family	$12,000	$24,000	$13,500	$27,000	$3,000
COVERED SERVICES (what you will pay)					
Preventative Care	No charge	10% coinsurance	No charge	10% coinsurance	No charge
Primary Care Office Visit	20% coinsurance	40% coinsurance	$25 copay	30% coinsurance	$25 copay
Specialist Office Visit	20% coinsurance	40% coinsurance	$50 copay	30% coinsurance	$50 copay
Urgent Care	20% coinsurance	40% coinsurance	$25 copay	30% coinsurance	$25 copay
Emergency Room	20% coinsurance		$100 copay + 20% coinsurance		$100 copay
Hospitalization	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance	$200 copay per day up to 3 days per calendar year
RETAIL PRESCRIPTION DRUG COVERAGE HIGHLIGHTS					
Generic	$10 copay*	$10 copay + 25%*	$10 copay	$10 copay + 25%	$10 copay
Preferred Brand	$25 copay*	$25 copay + 25%*	$30 copay	$30 copay + 25%	$30 copay
Non-Preferred Brand	$60 copay*	$60 copay + 25%*	$80 copay	$80 copay + 25%	$80 copay
Self-Injectables	$65 copay*	$65 copay + 25%*	$65 copay	$65 copay + 25%	$65 copay
Specialty	$60 copay*	Not covered	$200 copay	Not covered	$200 copay

*Subject to deductible then copays apply. Approved preventative medications are paid prior to deductible as the listed copays.

Dental Insurance

MetLife

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. For a complete list of your in-network and out-of-network benefits, please refer to your Dental Insurance Summary Plan Description, located on the staff website. Visit **www.metlife.com** to find an in-network provider.

DENTAL COVERAGE HIGHLIGHTS	In-Network % of Negotiated Fee	Out-of-Network 90% of Reasonable & Customary
Annual Deductible Individual Family	 $50 $150	 $50 $150
Annual Benefit Maximum Per Person	$1,750	$1,750
Orthodontia Lifetime Maximum Per Person	$1,500	$1,500
Implant Annual Maximum Per Person	$1,000	$1,000
Preventative Care Oral exams, cleanings, x-rays, etc.	100%	75%
Basic Services Root canals, fillings, simple extractions, etc.	85%	60%
Major Services Crowns, inlays, onlays, dentures, etc.	55%	30%
Orthodontia Services	50%	50%

Vision Insurance

VSP

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. The District's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. For a complete list of your in-network and out-of-network benefits, please refer to your Vision Insurance Summary Plan Description, located on the staff website. Visit **www.vsp.com** to search for an in-network provider. Vision coverage is only available with enrollment in the health plan.

VISION COVERAGE HIGHLIGHTS	In-Network VSP Signature Network	Out-of-Network
Exam Once every 12 months	$10 copay	Reimbursed up to $45
Prescription Glasses	$25 copay	See Frame and Lenses
FRAMES		
Frames Once Every 24 months • $150 allowance for a wide selection of frames • $170 for featured frames • 20% savings on the amount over your allowance • $70 Walmart / Sam's Club / Costco frame allowance	Included in Prescription Glasses up to the limits listed to the left	Reimbursed up to $70
Lenses Once every 12 months • Single vision / lined bifocal / lined trifocal / lenticular	Included in Prescription Glasses	Reimbursed up to $30 / $50 / $65 / $100
Lens Enhancements Once every 12 months • Standard progressive • Premium progressive • Custom progressive	$0 copay $80 - $90 copay $120 - $160 copay	Reimbursed up to $45 Reimbursed up to $45 Reimbursed up to $45
Contact Lenses Once every 12 months; in lieu of lenses / frames glasses $150 allowance for contacts and contact lens exam (fitting and evaluation)	$0	Reimbursed up to $105
Diabetic Eyecare Plus Program (as needed) • Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD) • Retinal screening for eligible Members with diabetes Limitations and coordination with medical coverage may apply. Ask your VSP Doctor for details.	$0 $20 per exam	N/A

Flexible Spending Accounts (FSA)

Further

The Medical FSA is available to employees enrolled in the PPO or HMO plans or not enrolled in the medical plans. The Dependent Care FSA is available to all employees.

What Are the Benefits of a Medical FSA?

There are a variety of different benefits of using an FSA, including the following:

- It saves you money. Allows you put aside money tax-free that can be used for qualified medical expenses.
- It's a tax-saver. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- It is flexible. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. If you do not use it, you lose it. You should only contribute the amount of money you expect to pay out of pocket that year. The maximum amount you may contribute each year to a Medical FSA is $3,050. You must re-enroll in the FSA each year.

Note: $610 in unused money at the end of the 2024 plan year can then be carried over to 2025. The carry-over does not count toward the annual maximum allowable contribution.

What Is a Dependent Care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute to a Dependent Care FSA each year is $5,000 (or $2,500 if married and filing separately).

FSA Case Study

FSAs provide you with an important tax advantage that can help you pay for healthcare or dependent care expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save you money. Jane is single with a gross income of $50,000. Since Jane expects to spend $3,050 in medical expenses in the next plan year, she decides to direct a total of $3,050 into her FSA.

	Without FSA	With FSA
Gross income	$50,000	$50,000
FSA contributions	$0	(-$3,050)
Taxable income	$50,000	$46,950
ESTIMATED TAXES		
Total*	$12,500	(-$11,737.50)
AFTER-TAX EARNINGS	**$37,500**	**$35,212.50**
Eligible out-of-pocket medical expenses	(-$3,200)	(-$0)
Remaining spendable income	$34,300	$35,212.50
SPENDABLE INCOME INCREASE	—	**$912.50**

* This example is for illustrative purposes only and assumes 25% of income in federal, state and social security taxes. Actual tax savings will depend on your contributions, applicable state tax rates and your personal tax situation. It is recommended you consult a tax advisor for all tax advice.

Health Savings Account (HSA)

Further

Available ONLY to employees enrolled in the CDHP

Health savings accounts (HSAs) are a great way to save you money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany a Health Savings Account Qualified Plan, such as a High Deductible Health Plan (HDHP). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

D303 will contribute $500 for single coverage and $1,000 for Family (2 or more) towards your Health Savings Account when you enroll in the CDHP Medical Plan. You are encouraged to contribute additional money, up to the annual maximum. Please note: If you are a new hire enrolling mid-year, D303 contributions will be prorated.

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- It saves you money. HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- It is portable. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the District.
- It is a tax-saver. HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

HSA Contribution Limits

The maximum amount that you can contribute to an HSA is $4,150 (individual) or $8,300 (family) in 2024. If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1	
HSA Balance	$1,000
Total Expenses: Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Year 2	
HSA Balance	$1,850
Total Expenses: Office visits: $100 Prescription drugs: $200 Preventative care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Basic Life/AD&D Insurance

The Standard

Life insurance can help provide for your loved ones if something were to happen to you. The District provides full-time employees with group life and accidental death and dismemberment (AD&D*) insurance in the amounts below.

	Administrators	St. Charles Educational Support Professionals (SCESP), Exempt and Confidential Employees and St. Charles Transportation and Maintenance (SCT&M)	St. Charles Certified Teachers (SCEA), St. Charles OTPT (SCEA), Mid-Valley Certified Teachers (MVSEA), Mid-Valley Non-Certified Support Staff (MVSEA)
Life/AD&D Benefit	2x Annual Earning Rounded up to the next $1,000	Flat $30,000	Flat $25,000
Life/AD&D Maximum	$400,000	N/A	N/A

The District pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact the Benefits Coordinator if you would like to check your benefit amount or update your beneficiary information.

Your designated beneficiary will receive a benefit to help ease their financial burden if you die. If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically!

HOW MUCH LIFE INSURANCE COVERAGE DO YOU NEED?

Depending on your personal situation, you may wish to purchase additional coverage that you can buy at affordable group rates.

Use this worksheet to estimate how much additional life insurance you need and see the details of the voluntary life on the following page.

When considering how much life insurance you need, it's important to think about your outstanding debt, ongoing expenses and the future plans of your family. Fill in the blanks to figure out how much life insurance you may wish to purchase.

Outstanding Debt - How much will be left for your family to pay?	
Mortgage balance	$_____
Other debt (credit cards, loans, car payment)	$_____
TOTAL (A)	**$_____ (A)**
Ongoing Expenses - How much do your dependents need each year?	
Utilities (electric, phone, cable, internet)	$_____
Medical costs, insurance	$_____
Food, clothing, gasoline	$_____
Saving contributions	$_____
TOTAL (B)	**$_____ (B)**
Future Plans - How much will loved ones need for the future?	
College	$_____
Other (retirement, long term care)	$_____
TOTAL (C)	**$_____ (C)**
Grant Total (A + B + C)	
Subtract existing coverage	$_____
Subtract company-paid life	$_____
Consider this amount of life insurance	**$_____**

*AD&D pays a benefit for loss of life or dismemberment resulting from an accidental bodily injury. Your beneficiary will receive 100% of the AD&D amount if you die as the result of an accidental injury. You will receive an accidental dismemberment benefit if you lose a hand, a foot, or the sight of an eye due to an accidental injury. The benefit paid is 50% of the AD&D amount for any 1 loss and 100% of the AD&D amount for any 2 or more losses.

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Voluntary Life/AD&D Insurance

The Standard

While the District offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage. With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your eligible dependent spouse and child(ren). If you waive coverage when it is first offered to you, future enrollment will be subject to evidence of insurability.

NEW HIRE NOTICE! If you are a new hire, this is your chance to receive Guarantee Issue for yourself and your dependents. If you do not take advantage of this benefit at your initial new hire enrollment but then wish to enroll at a later date, you will be subject to evidence of insurability (answer medical questions).

VOLUNTARY LIFE/AD&D COVERAGE HIGHLIGHTS	
Life/AD&D Maximum	Employee: $200,000 Spouse: $150,000 Child(ren) under age 26: $10,000
Guarantee Issue Amount	Employee: $150,000 Spouse: $50,000 Note: If you enroll when first offered, you receive up to the listed amount without having to answer medical questions

Important – Please Read!

- Dependents may have a delayed effective date based on his/her medical status at time of enrollment. Please refer to the policy certificate or contact the benefits coordinator for more details.
- Please update your beneficiaries periodically! If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or contact the benefits coordinator for more information.

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Employee Assistance Program

Northwestern Medicine

The EAP provides free and confidential assistance for personal or work-related issues. The EAP can help you move toward a better work-life balance through assessment, short-term counseling and referral services for more in-depth counseling or care. The EAP is available 24/7/365 for emergencies.

The EAP also offers a website which features a comprehensive level of articles, assessments, and audio and video files covering emotional well-being, health and wellness, and workplace issues, as well as child care, elder care, adoption, and education.
https://helpwhereyouare.com/CompanyLogin/1572/NWM
Password: **STC303**

Northwestern Medicine EAP
888.933.1327

TTY for the hearing impaired
630.933.4833

The Program Provides Support for a Range of Personal Concerns, Including:

- Marital, family and relationship issues
- Stress, depression and anxiety
- Self-esteem issues
- Substance abuse
- Health and wellness
- Grief, trauma and loss
- Life transitions and change
- Financial and legal difficulties
- Child care or elder care needs

The EAP also Offers Consultation and Coaching for Work-Related Issues, such as:

- Conflicts
- Effective communication
- Career skills
- Compassion fatigue
- Job burnout
- Professional grief

Always Confidential

Confidentiality in the EAP will be maintained with the rules established by federal and state law and professional ethical standards. Disclosure of information shared by the employee to any other source without the prior written consent of that employee is prohibited.

EAP Care at No Cost

EAP care at no cost EAP services are free of charge to you and members of your household. If your needs go beyond the scope of EAP services, a referral to a provider in your insurance plan or a community resource will be provided.

Call an EAP Counselor if:

- You don't know where else to turn for help You would like some coaching on what to do about a problem
- You would like some coaching on what to do about a problem
- You keep telling yourself the problem will get better, but it never does
- You spend too much time worrying about a problem and your job, family life or health is being affected

Telemedicine

MDLive

Available to all employees enrolled in either the district's PPO or CDHP medical plan.

MDLive can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. With 24/7/365 access to U.S. board-certified doctors, you can access medical care for only a small copay amount, from home or on the road—and in some cases, doctors can write a prescription to a local pharmacy near you.*

How Does It Work?

Log in to your account or register if you don't have one set-up. Then, contact MDLive from anywhere—and let the doctor come to you!

MDLive

Phone: **888.676.4204**
Online: **MDLIVE.com/bcbsil**

Behavioral Health:

MDLive doctors can then diagnose non-emergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.*

*Prescription services may not be available in all states.

When Can I Use It?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.

Common Conditions We Treat

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore Throat
- Pink eye
- Urinary tract infections and more!

Save Money and Time!

With extremely low or no consult cost MDLive provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

Meet Our Doctors!

- U.S. board-certified with an average of 15 years of practice experience
- U.S. residents and licensed in your state

Behavioral Health Conditions

- Anxiety
- Depression
- Stress management and more

Meds Your Way

It's Part of Your Benefit Plan

There's nothing you need to do to start using the MedsYourWay program. It's part of your benefit plan, and there's no sign-up. We're making it easy to help keep your family healthy and your out-of-pocket costs low. You can find in-network pharmacies and review your estimated drug costs by logging in to your Blue Access for Members℠ (BAMSM) account or **MyPrime.com** account.

BlueCross BlueShield of Illinois

MedsYourWay® Connects You with Prescription Discounts

MedsYourWay[1] is a new prescription drug discount program that works with your Blue Cross and Blue Shield of Illinois (BCBSIL) pharmacy benefit. We're saving you time by finding lower prices for you.

How it Works

1. Fill your prescription at a participating in-network retail pharmacy.
2. When you pick up your prescription, show your BCBSIL member ID card to your pharmacist.
3. MedsYourWay automatically compares prices from participating drug discount cards to your cost-share amount under your BCBSIL pharmacy benefits.
4. You pay the drug discount card price or your member cost-share, whichever is lower, for an eligible medicine.
5. Plus, what you pay will count toward your plan deductible and/or yearly out-of-pocket maximum amount if you have one.

All you need is your BCBSIL member ID card.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Medical Member Resources

Blue Access for Members – BCBSIL

Blue Access for Members℠

Get all the advantages your health plan offers

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

With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID card – or print a temporary one
- Visit Healthcare School to see articles and videos to help you make the most of your benefits

Blue Cross and Blue Shield of Illinois, a Division of Healthcare Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. 22195.1014

Blue Access Mobile℠

Blue Access Mobile brings convenient, secure access to your mobile phone.

From your mobile phone web browser, you can:

- Register or log in to your secure member site – Blue Access for Members SM – to view coverage details, access or request identification (ID) cards, check claims status, manage your user profile, use the Message Center and view health and wellness information
- Find a doctor, hospital or urgent care facility
- Access Healthcare Reform and Healthcare 101 to view general health insurance information and terminology
- Shop for insurance and get a quote before applying
- Locate Blue Cross and Blue Shield of Illinois (BCBSIL) contact information

It is easy to experience Blue Access Mobile.

Simply go to **www.bcbsil.com** from your mobile phone Web browser. There is no registration required to access the mobile site. However, BCBSIL members must enter their user name and password to log in to Blue Access for Members.

ID Theft Protection Services

BCBS makes available at no additional cost to your identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBS's designated outside vendor and acceptance or declination of these services is optional to you.

If you wish to accept such identity theft protection services, you will need to individually enroll in the program online at **www.bcbsil.com** or telephonically by calling the toll-free telephone number on your identification card.

Services may automatically end if you no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and BCBS does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this Certificate.

It's easy to get started!

- Go to **www.bcbsil.com/member**
- Click Register Now
- Use the information on your BCBSIL ID card to complete the registration process.

Text* BCBSILAPP to 33533 to get the BCBSIL app that lets you use BAM while you're on the go. Or visit **www.bcbsil.com/mobile** for more information.

*Message and data rates may apply

Medical Member Resources

Livongo Diabetes Management Solution – BCBSIL

Blue Cross and Blue Shield of Illinois (BCBSIL) is providing a diabetes management program that combines a connected glucose meter and personal support for those employees enrolled in the PPO or CDHP medical plan. Program benefits include:

- Real-time personalized messaging on the Livongo-connected blood glucose meter
- Certified diabetes educators available 24/7/365
- Instant interventions when blood glucose readings are out of range
- Optional notifications for high and low readings to give loved ones and providers insight
- Test strips and lancets at no extra cost, delivered right to the member's door
- Member-initiated reporting to a Blue Cross and Blue Shield of Illinois clinician with blood glucose readings and trends to enable more focused conversations

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Healthcare provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered healthcare service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered healthcare service, usually when you receive the service.
- **Deductible**—The amount you owe for healthcare services each year before the Plan begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health Plan to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **In-network Provider**—A provider who is contracted with your health Plan to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health Plan.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your healthcare during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered healthcare services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, healthcare practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for healthcare expenses.
- **HMO**—Health maintenance organization
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- QHP—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post- secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA.

Women's Health & 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 the plan.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid- year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or

2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

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 **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 **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, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/ health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/ index.html 877.357.3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid. georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

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.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

St. Charles CUSD 303 (D303) is committed to the privacy of your health information. The administrators of the St. Charles CUSD 303 (D303) Group Medical Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

HIPAA Special Enrollment Rights

St. Charles CUSD 303 (D303) Group Medical Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the St. Charles CUSD 303 (D303) Group Medical Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice of Creditable Coverage

Important Notice from St. Charles CUSD 303 (D303) 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 St. C**harles CUSD 303 (D303) 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. **St. Charles CUSD 303 (D303) has determined that the prescription drug coverage offered by the medical plan 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 15 to December 7.

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 current St. Charles CUSD 303 (D303) coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current St. Charles CUSD 303 (D303) coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with St. Charles CUSD 303 (D303) 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 St. Charles CUSD 303 (D303) changes. You also may request a copy of this notice at any time.

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

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

For More Information About Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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 **www.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:	October 6, 2023
Name of Entity/Sender:	St. Charles CUSD 303 (D303)
Contact:	Human Resources
Address:	201 S 7th St. Saint Charles, Illinois 60174
Phone Number:	630.513.3030

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

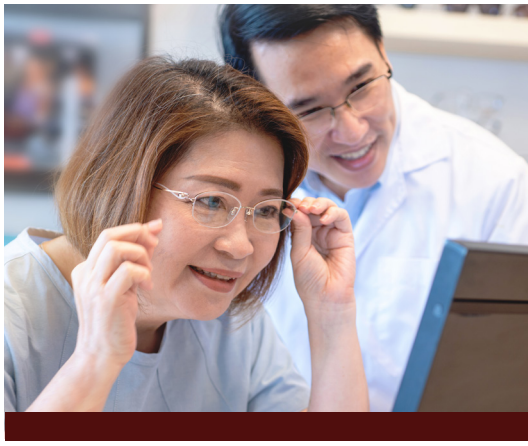
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

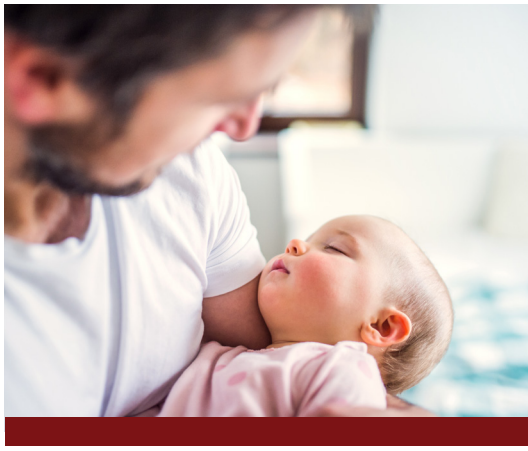
How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.





This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN24BGSC