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# EMPLOYEE BENEFITS

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*YOUR GUIDE.*

*YOUR ADVOCATE.*



# GLENVIEW SCHOOL DISTRICT 34

## Welcome!

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

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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.

### BENEFITS OVERVIEW

#### Eligibility

- As defined by your Collective Bargaining Agreement
- Benefits are effective on the date of employment

#### Qualifying Life Events

Elections you make at this time will remain in effect until our next Open Enrollment period. In addition, if you decline coverage for yourself and/or your dependent(s) when first becoming eligible, you must wait until the next Open Enrollment period to enroll. However, if you experience a qualified life event during the year, you may make changes to your elections at that time.

#### Qualified life events include:

- **Change in status:** Marriage, divorce, legal separation, annulment or death
- **Change in number of dependents:** Birth, death, adoption/ placement for adoption or dependent reaching limiting age
- **Change in employment status** of employee, dependent or spouse that affects that individual's eligibility
- **Change in employee, spouse or dependent coverage** on spouse's plan during spouse's Open Enrollment period
- **Changes in entitlement** to Medicare, Medicaid or State Children's Health Insurance Program (CHIP)\* for employee, dependent or spouse
- **Change in eligibility for group health plan premium assistance** under Medicaid or CHIP\* for employee, dependent or spouse

\*In such cases you have 60 days to notify HR of the event instead of 30.

It is your responsibility to notify **Lauren Hackett** (Benefits Department) within **30 days** of the event. If you fail to do so, you will not be able to enroll or make changes until the next Open Enrollment period. When you, your dependent(s) or your spouse become enrolled as a result of a qualified life event, coverage will be made effective retroactive to the date of the event.

For more information, please contact **Lauren Hackett** at extension 5065.

# GLENVIEW SCHOOL DISTRICT 34

## MEDICAL COVERAGE

Administered by Blue Cross® Blue Shield® of Illinois (BCBSIL)

### HMO Comparison Charts

Plan Feature	HMO A HMO Illinois Group #: H56154	HMO B HMO Blue Advantage Group #: B56153
	In-Network	In-Network
<b>ANNUAL DEDUCTIBLE</b>		
<b>Employee Only</b>	\$0	\$0
<b>Family</b>	\$0	\$0
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>		
<b>Employee Only</b>	\$1,500	\$1,500
<b>Family</b>	\$3,000	\$3,000
<b>OFFICE VISIT</b>		
<b>Primary Care Physician</b>	\$10 copay	\$20 copay
<b>Specialist</b>	\$10 copay	\$40 copay
<b>Preventive Care</b>	Plan pays 100%	Plan pays 100%
<b>Emergency Room</b> (copay waived if admitted)	\$50 copay, then plan pays 100%	\$50 copay, then plan pays 100%
<b>Inpatient Hospital Stay</b>	Plan pays 100%	Plan pays 100%
<b>PRESCRIPTION DRUGS</b>		
<b>Retail</b> (Up to a 30-day supply)	Generic \$10 Preferred \$20 Non-Preferred \$35 Specialty \$35	Generic \$5 Preferred \$25 Non-Preferred \$50 Specialty \$50
<b>Mail Order</b> (Up to a 90-day supply)	Generic \$10 Preferred \$20 Non-Preferred \$35	Generic \$10 Preferred \$50 Non-Preferred \$100

**NOTE:** Occupational therapy, speech therapy and physical therapy has a combined calendar year maximum benefit of 60 visits.

Hospitals that ARE included in the HMO Illinois Network, that are NOT included in the HMO Blue Advantage Network are:

MG #	MG Name	Hospital Name
374	Franciscan PHO Northern IN Crown Point	Franciscan St. Anthony Health
487	Northwestern Medicine Phys Partners North Region	Lake Forest Hospital
489	Northwestern Med Phys Partners – NW Mem Hosp	Northwestern Memorial Hospital

**Note:** Providers jump in- and out-of-network all the time. Make sure to check [bcbsil.com](http://bcbsil.com) for up to date provider information.

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## PPO Comparison Charts

Plan Feature	PPO 750 Group #: P58206		PPO 1000 Group #: PI4868		HSA 2800 PPO Group #: PI4869	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>ANNUAL DEDUCTIBLE</b>						
<b>Employee Only</b>	\$750	\$1,500	\$1,000	\$2,000	\$2,800	\$2,800
<b>Family</b>	\$1,500	\$3,000	\$2,000	\$4,000	\$5,600	\$5,600
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>						
<b>Employee Only</b>	\$2,750	\$5,500	\$4,000	\$8,000	\$2,800	\$5,600
<b>Family</b>	\$5,500	\$11,000	\$8,000	\$16,000	\$5,600	\$11,200
<b>OFFICE VISIT</b>						
<b>Primary Care Physician</b>	\$20 copay	Plan pays 60% after deductible is met	\$25 copay	Plan pays 60% after deductible is met	Plan pays 100% after deductible is met	Plan pays 80% after deductible is met
<b>Specialist</b>	\$40 copay	Plan pays 60% after deductible is met	\$50 copay	Plan pays 60% after deductible is met	Plan pays 100% after deductible is met	Plan pays 80% after deductible is met
<b>Preventive Care</b>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
<b>Emergency Room</b> (copay waived if admitted)	\$200 copay, then plan pays 100%, no deductible		\$200 copay, then plan pays 100%, no deductible		Plan pays 100% after deductible is met	
<b>Inpatient Hospital Stay</b>	Plan pays 80%, no deductible	Plan pays 60%, no deductible	Plan pays 80%, no deductible	Plan pays 60%, no deductible	Plan pays 100% after deductible is met	Plan pays 80% after deductible is met
<b>PRESCRIPTION DRUGS (TIER 1/TIER 2/TIER 3)</b>						
<b>Retail</b> (Up to a 30-day supply)	Generic \$10 Preferred \$25 Non-Preferred \$50 Specialty \$50		Generic \$10 Preferred \$40 Non-Preferred \$60 Specialty \$60		Plan pays 100% after deductible is met	
<b>Mail Order</b> (Up to a 90-day supply)	Generic \$20 Preferred \$50 Non-Preferred \$100		Generic \$20 Preferred \$80 Non-Preferred \$120		Plan pays 100% after deductible is met	N/A

**NOTE:** Occupational therapy, speech therapy and physical therapy has a combined calendar year maximum benefit of 60 visits.

The PPO plans are under the Performance Drug List and utilize the Advantage Network. This network includes all Walgreens pharmacies; however, CVS is excluded. Members needing specialty medications will be required to use Accredo Specialty Pharmacy.

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## What is a HDHP and HSA?

### The High Deductible Plan with Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) offers comprehensive healthcare coverage at a lower premium and higher deductible than traditional healthcare plans.

The HDHP also features a health savings account (HSA) that enables you to pay for current, qualified healthcare expenses and save for future expenses on a tax-free basis. You have the opportunity to set aside funds in your HSA before taxes through convenient payroll deductions (refer to “How Your HSA Is Funded”).

**PLEASE NOTE: YOU MUST ELECT THE HDHP (HSA2800) TO CONTRIBUTE TO AN HSA.**

## How Your HSA Is Funded

### Your Contributions

There are several ways to contribute money to your HSA:

- **Pre-tax contributions** through payroll deductions
- **After-tax cash contributions** that are deductible when you file your taxes
- **Catch-up contributions** up to \$1,000 per year if you are age 55 or older (until you enroll in Medicare)

### Total Annual Contribution Limit

It is important to note that your contributions, when combined with those contributed by the company, may not exceed the IRS annual maximum of \$3,850 for individual coverage and \$7,750 for family coverage in 2023. Note: Individuals 55 and older may make additional “catch-up” contributions up to \$1,000 each year until they enroll in Medicare.

Note: You can only use HSA funds as they are deposited in your account. You can always reimburse yourself later once you have accumulated funds in your account.

### Qualified Healthcare Expenses

HSAs enable you to pay for the following qualified healthcare expenses on a tax-free basis:

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502.
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

**If you are considering the HDHP, be sure that you are aware of your prescription costs. Certain prescriptions are very costly. Until you meet your deductible, you will pay the full cost of the prescription. The prescription copay applies after you meet your deductible.**

## ADVANTAGES OF AN HSA

### Triple-Tax Advantage

1. **Pre-tax Payroll Contributions:** You contribute pretax funds through payroll deductions, meaning the money comes out of your paycheck before federal income tax is calculated. This, in turn, reduces the amount of taxable income, so less tax is withheld from your paycheck.
2. **Earned Interest Tax-free:** Funds grow tax-free, and unused funds roll over year to year.
3. **Investment Opportunities:** You can withdraw funds tax-free to pay for qualified healthcare expenses now and in the future—even in retirement.

### Control

You own and control the money in your HSA. You decide how you want to spend it or if you want to spend it. You can use it to pay for doctor’s visits, prescriptions, braces, glasses—even laser vision correction surgery.

### Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax-free.

### Savings Potential

There is no “use it or lose it” rule. Your account grows over time as you continue to roll over unused dollars from year to year.

### Portability

Your HSA is yours for life. The money is yours to spend or save, regardless of whether you change health plans,\* retire or leave the company.

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## HSA, HRA, and FSA

	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)	Limited-Purpose FSA
<b>Description</b>	A tax-advantaged medical savings account available to employees enrolled in a High Deductible Health Plan	An employer funded account that reimburses employees for qualified medical expenses.	An account to reimburse with pre-tax dollars for eligible medical expenses	An account to reimburse with pre-tax dollars for eligible dental and vision expenses only (not medical)
<b>Who Can Contribute to the Account?</b>	Employer and eligible employees	Employer Only	Employee	Employee
<b>Age Limit</b>	Yes, contributions are not allowed for those enrolled in Medicare	None	None	None
<b>Limits on Amounts</b>	2023 Limits: Single: \$3,850 Family: \$7,750 • For those 55 and older, the limit is increased by \$1,000 • Spouses are limited to combined family maximum if either has family coverage	Employer sets limits (\$250)	2023 limit: \$3,050	2023 limit: \$3,050
<b>Consequences for Excess Contributions</b>	Subject to income tax and 6% excise tax	NA	N/A	N/A
<b>Reimbursable Medical Expenses</b>	All §213 medical expenses (including over-the-counter drugs with a prescription) and long-term care expenses but not health insurance premiums (subject to exceptions)	Medical expenses subject to the PPO1000 deductible	All §213 medical expenses (including over-the-counter drugs with a prescription) except long-term care expenses and insurance premiums	Only dental and vision services listed under Section 213(d) of the Internal Revenue Code
<b>Distributions for Nonqualified Medical Expenses</b>	Subject to income tax and a 20% penalty (distributions after death, disability or reaching age 65 are exempt from the 20% penalty)	Not Allowed	Not allowed	Not allowed
<b>Are Premiums for Medical Coverage Reimbursable?</b>	Yes, COBRA and qualified long-term care coverage, health plan coverage while receiving unemployment compensation and health plan coverage (other than Medicare supplemental insurance) for those age 65 or older	No	No	No
<b>Can Dollars Rollover?</b>	Yes	No	No	No
<b>Is It Portable?</b>	Yes	No	No	No
<b>When Are Funds Available for Use?</b>	Funds are only available as contributions are made to the account	Funds are available after \$750 of the \$1,000 deductible has been met.	Funds are available on first day of plan year	Funds are available on first day of plan year
<b>Can I Have Another Account with It?</b>	Yes, you can have a limited-purpose FSA, which can only be used for eligible dental and vision services	Yes, you can have a FSA	No	Yes, you can have a Health Savings Account to help you save and pay for qualified medical expenses

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## What is an HRA?

A Health Reimbursement Arrangement (HRA) is funded by your employer to help with your out-of-pocket deductible expenses.

Having an HRA allows your employer to offer health insurance plans with higher deductibles, which are cost effective. But rather than putting a bigger cost burden on to you, your employer has opted to reimburse you for medical expenses (as defined in your health insurance plan) that are applied toward the deductible, so you pay less out of pocket.

The HRA reimbursements are tax free for you!

## How the HRA Works

The Health Reimbursement (HRA) will refund you for any medical expenses that are subject to the deductible. The first \$750 of the \$1,000 deductible must first be met before the HRA starts paying. The HRA will reimburse up to \$250 in medical expenses subject to the deductible. Any unused HRA money will be forfeited at the end of the calendar year.

In order to qualify for the HRA you must meet the below criteria:

- Enrolled in the PPO 1000 plan under Employee Only (single) coverage.
- Be part of the **Certified Staff hired prior to the 2019\_2020 School Year** or **Support Staff hired prior to the 2020\_21 school year class.**

**The Health Reimbursement (HRA) will be administered by BCBSIL. Providers will automatically be reimbursed by BCBSIL once a claim is received and you are at the \$750 deductible. You will not get a separate HRA debit card. Your BCBS ID card will also serve as your HRA.**



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## VISION BENEFIT

Administered by Blue Cross® Blue Shield® of Illinois (BCBSIL)

Your PPO 750, PPO 1000, HMO, and BAHMO plans include a vision benefit. In order to receive the benefit you must be enrolled in one of the medical plans.

Coverage	You have this coverage if:	Vision Network	Features	Frequency	Benefit
<b>PPO Plan</b>	You are a BCBSIL PPO Plan member	Any provider	Exam Frame Lenses Contact Lenses	Every 12 months Every 24 months Every 24 months Every 24 months	\$25 allowance** \$25 allowance** \$20 to \$100 allowance** \$60 allowance**
<b>HMO Plan***</b>	HMO Plan member	EyeMed	Exam Frame Lenses Contact Lenses	Every 12 months Every 24 months Every 24 months Every 24 months	\$0 \$125 allowance \$75 allowance \$75 allowance

\*This is not a stand alone vision plan. The HDHP does not include a vision benefit.

\*\*You must submit a claim form to receive reimbursement.

\*\*\*HMO Members will receive an EyeMed card to share with their EyeMed provider.

## EyeMed Vision Discount Program

Coverage	You have this discount if:	Vision Network	Features	Frequency	Benefit
<b>EyeMed Vision Discount Program</b>	You are a BCBSIL HMO or PPO Plan member	EyeMed Advantage Network	Exam Frame Standard Lenses Premium Progressive Lens Enhancements Contact Lenses Fitting LASIK	Unlimited Unlimited Unlimited Unlimited N/A Unlimited Unlimited N/A	\$50 routine exam 35% off retail price \$50-\$135 30% off retail price Additional cost \$10 off 15% discount off retail 15% discount off retail or 5% off promotional price

### To receive the discount:

1. Locate an in-network provider: **MUST USE THESE EYEMED ADVANTAGE NETWORK LINKS**
  - PPO members: visit [eyemedexchange.com/blue365](http://eyemedexchange.com/blue365), click Find a Provider, enter ZIP Code, Get Results.
  - HMO members: visit [eyemedvisioncare.com/bcsil](http://eyemedvisioncare.com/bcsil), click Find a Provider, enter ZIP Code, Get Results.
2. The provider should apply the applicable discounts shown above; otherwise, please call [844.684.2254](tel:844.684.2254) for further assistance.





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## DENTAL COVERAGE

Administered by Blue Cross® Blue Shield® of Illinois (BCBSIL)

Plan Feature	Dental PPO Plan BlueCare Dental PPO Group #: P64507	
	In-Network	Out-of-Network
<b>Annual Deductible</b> (single/family)	\$50/\$150	
<b>Annual Maximum Benefit</b>	\$1,500 per person	
<b>Preventive</b>	Plan pays 100%, no deductible	Plan pays 100% of U&C*, no deductible
<b>Basic</b>	Plan pays 80% of maximum	Plan pays 80% of U&C* after deductible
<b>Major</b>	Plan pays 80% of maximum	Plan pays 80% of U&C* after deductible
<b>Orthodontia</b>	Plan pays 50% of maximum allowance, no deductible	Plan pays 50% of U&C*, no deductible
<b>Orthodontia Lifetime Maximum</b>	\$1,000	



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## FLEXIBLE SPENDING PROGRAM

Administered by Allied Benefits System

Flexible spending accounts (FSAs) allow you to set aside pre-tax funds to pay for eligible health and/or dependent care expenses before your federal and Social Security taxes are calculated. You have the following options:

Healthcare FSA	
Eligible Expenses	Qualified medical, dental and vision expenses not covered by insurance
Maximum Annual Contribution	\$3,050
Minimum Annual Contribution	\$300
Limited-Purpose Healthcare FSA (for HSA participants)	
If you enroll in the HSA medical plan, you may only participate in a limited-purpose Healthcare FSA. This type of FSA allows you to be reimbursed for eligible dental, orthodontia and vision expenses while preserving your HSA funds for eligible medical expenses.	
Dependent Care FSA	
Eligible Expenses	Qualified dependent care, such as child or eldercare
Maximum Annual Contribution	\$5,000 (or \$2,500 if married and filing separately)
Minimum Annual Contribution	\$300

THE GOVERNMENT REQUIRES THAT YOU ENROLL EACH YEAR TO PARTICIPATE IN AN FSA, EVEN IF YOU WERE ENROLLED THE YEAR BEFORE.

### “Use it or lose it.”

The IRS requires that any unused funds you have set aside for eligible expenses that are still in your account at the end of the plan year (2/28/2024) must be claimed by submitting your eligible expenses no later than 3/31/2024. Any unused funds will be forfeited.

### Qualifying Expenses

For a complete list of qualified healthcare expenses, visit:

[https://www.irs.gov/publications/p502#en\\_US\\_2021\\_publink1000178852](https://www.irs.gov/publications/p502#en_US_2021_publink1000178852).



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## BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Administered by [Voya Financial](#)

This coverage is provided by the company at no cost to you as specified below.

Employee Life and AD&D	
Amount	<b>All Eligible Superintendents and Administrators:</b> 3x your basic yearly earnings up to a maximum of \$400,000
	<b>All Eligible Teachers:</b> 1x your basic yearly earnings up to a maximum of \$50,000
	<b>All Other Eligible Employees:</b> 1x times your basic yearly earnings up to a maximum of \$400,000
	<b>All Eligible Retired Administrators With Five or More Years of Service:</b> 3x your basic yearly earnings up to a maximum of \$400,000

## SUPPLEMENTAL LIFE COVERAGE

Administered by [Voya Financial](#)

You also have the opportunity to purchase additional life insurance coverage for yourself and your dependents at group rates. The chart below shows the coverage available. Note: Spouse and child coverage is only available when the employee elects voluntary coverage for him or herself. This coverage applies to all eligible superintendents, administrators, teachers and other eligible employees and their eligible dependents.

	Amount	Guaranteed Issue
<b>Employee</b>	1-5x times your basic yearly earnings up to a maximum of \$300,000	Lesser of \$50,000 or 5x basic yearly earnings
<b>Spouse</b>	\$5,000 to \$150,000, chosen in increments of \$5,000, not to exceed 50% of the employee's insurance amount	\$20,000
<b>Child(ren)</b>	From 15 days but less than six months of age: \$1,000	\$10,000
	Six months but less than 26 years of age: \$2,000 increments up to \$10,000	

## LONG-TERM DISABILITY

Administered by [Voya Financial](#)

This coverage is also provided by the company at no cost to you as specified below.

Long-Term Disability (LTD) Coverage Features	
<b>Income Replacement</b>	<b>Superintendents and Administrators:</b> 66.67% of monthly earnings <b>Teachers:</b> 60% of monthly earnings
<b>Monthly Maximum Benefit</b>	<b>Superintendents and Administrators:</b> \$15,000 <b>Teachers:</b> \$6,000
<b>When Benefit Begins</b>	<b>Superintendents, Administrators and Teachers:</b> 2 years regular occupation
<b>Maximum Benefit Period</b>	Social Security Normal Retirement Age



## GLENVIEW SCHOOL DISTRICT 34

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### EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by ComPsych Corporation

We understand that it can be difficult to manage family, work-related and personal issues. That's why we offer an EAP at no cost to you. To help guide you through difficult situations or simply assist you with day-to-day tasks like finding a last-minute dog sitter, trained professionals work with you as you search for solutions. The program is completely confidential and can help you work through issues related (but not limited) to:

- **Family:** Child care, eldercare, communication, conflict, serious illness and parenting issues
- **Relationships:** Domestic violence, dual careers, conflict resolution and separation/ divorce issues
- **Your job:** Career, interpersonal and job "burnout" issues
- **Finances:** Budget control, credit problems and identity theft issues
- **Emotional well-being:** Anger, anxiety, depression, eating disorders, grief/loss, life transition, addiction and stress issues



# GLENVIEW SCHOOL DISTRICT 34

## BENEFITS CONTACT DIRECTORY

Topic	Contact	Phone Number	Website
<b>General Benefits Questions</b>	Lauren Hackett	847.998.5065	lhackett@glenview34.org
<b>Medical</b>	BCBSIL	HMO: 800.892.2803 PPO: 888.979.4516	www.bcbsil.com
<b>Health Savings Account (HSA)</b>	First American Bank	866.449.1150	firstambank.com
<b>Dental</b>	BCBSIL	800.367.6401	www.bcbsil.com
<b>Flexible Spending Accounts (FSAs)</b> (Healthcare and dependent care FSAs)	Allied Benefit Systems	800.288.2078	www.alliedbenefit.com Group Number: A04162A
<b>Basic Life and Accidental Death &amp; Dismemberment (AD&amp;D)</b>	Voya Financial	800.955.7736	www.voya.com
<b>Supplemental Life</b>	Voya Financial	800.955.7736	www.voya.com
<b>Disability</b>	Voya Financial	800.955.7736	www.voya.com
<b>Employee Assistance Program (EAP)</b>	ComPsych Corporation	800.272.7255	https://www.guidanceresources.com/groWeb/login/login.xhtml Group Number: COM589
<b>Glenview 34 Benefits Website</b>	<a href="https://glenviewsd34.benefithub.com/">https://glenviewsd34.benefithub.com/</a>		



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## IMPORTANT NOTICES

### Mental Health Parity Act

Per the Mental Health Parity Act, benefits for mental health and substance-use disorder must be treated like benefits for regular medical and surgical care. For example, if there is no limitation on the number of days for inpatient and number of visits for outpatient medical care, then there can be no limitation for mental health and substance-use disorder treatments. As always, treatments must be medically necessary to qualify for coverage. Plan participants should review their plan's certificate of coverage or benefit document for specific information about coverage, limitations and exclusions for mental healthcare and substance-use disorder treatments.

### Women's Health and Cancer Rights Act

On January 1, 1999, a federal law, the Women's Health and Cancer Rights Act of 1998, became effective, which affects our company plan options. This law requires group health plans that provide coverage for mastectomies (ours does) and to also provide coverage for reconstructive surgery and prostheses following mastectomies. As required under the law, we have included this notice to inform you about it.

The law mandates that a participant or eligible beneficiary who is receiving benefits, on or after the law's effective date (January 1, 1999 for our Plan), for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

If you have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact BCBS of Illinois.

### Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. To help you make an informed choice, the company makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about our health coverage in a standard format, to help you compare across options.

The SBC also includes a Glossary of Health Coverage and Medical Terms to help you better understand healthcare terms used in the SBC. You can obtain a copy of the SBC at no cost to you by contacting BCBS of Illinois.

Please note: This guide is intended to provide you with highlights of our benefits program. It is not intended to address all details. Actual benefit coverage is specified in the Summary Plan Descriptions (SPDs). In the event of any differences between this guide and the SPDs, the SPDs will govern.



# GLENVIEW SCHOOL DISTRICT 34

## GLOSSARY OF HEALTH INSURANCE AND MEDICAL TERMS

**Beneficiary:** The person(s) you name to receive certain benefits (such as life insurance) upon your death

**Brand Name Drugs:** Medications are marketed under a trademark-protected name and are often available from only one manufacturer

**Coinsurance:** The percentage of covered medical or dental expenses that you must pay. For example, if your plan pays 80%, you must pay the remaining 20%.

**Copay:** A fixed amount you pay for a covered healthcare service, usually at the time of service.

**Deductible:** The amount of medical or dental expenses you must pay each year before your plan begins paying benefits.

**Evidence of Insurability (EOI):** An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

**Explanation of Benefits (EOB):** The document you receive from the insurance company after your claim is filed and processed. The EOB shows how much of the expense the plan covered and how much you may be expected to pay.

**Formulary Brand Name Drugs:** A list of prescribed medications that are preferred by your plan because they are safe, effective alternative to other generics or brands that may be more expensive. The formulary has a wide selection of generic and brand-name medications.

**HIPAA (Health Insurance Portability and Accountability Act of 1996):** A federal law that addresses the privacy of patient health information. The "privacy" regulations give patients greater access to their own medical records and more control over how their personal health information is used. Also, the law defines the obligations of healthcare providers and health plans to protect patient records.

**Hospital Outpatient Care:** Care in a hospital that doesn't require an overnight stay.

**In-Network Provider:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

**Maximum annual benefit:** The maximum amount the plan pays for specific services (such as dental or chiropractic) for a covered individual, each plan year.

**Medically necessary:** Services and supplies that the insurance company determines to be consistent with generally accepted practices for the diagnosis of an illness or injury, or the medical care of a diagnosed illness or injury. Only medically necessary services and supplies are covered by the plan.

**Out-of-Network Provider:** The facilities, providers and suppliers who don't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

**Out-of-pocket Limit (OPX):** Is the most you have to pay for covered medical expenses in a year. Once you've reached the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. This limit never includes your premium, balance-billed charges or charges the plan doesn't cover.

All charges applied to the Individual OPX amount will be applied towards the Family OPX amount. Once a person meets their Individual OPX, no more OPX is required for that Individual. When the Family OPX is reached, no further OPX will have to be satisfied for the remainder of that calendar/ contract year. No participant will contribute more than the Individual OPX amount to the Family OPX amount.

**Preauthorization:** A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.

**Primary Care Physician:** A physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. The final following types of providers are PCPs: family practitioners, general practitioners, pediatricians, internal medicine, and gynecologists.

**Specialist:** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Step Therapy:** A prescription drug plan requirement for prescribers to use a lower-cost drug before "stepping up" to a higher-cost drug.

**Quantity Limits:** A prescription drug plan requirement that limits the number of doses of certain drugs that can be dispensed at any given time.



*This benefit summary prepared by*



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