Community Consolidated School District 62

January 1, 2025 – December 31, 2025 Benefit Summary

- Eligibility
- Who's Who of Your Plans
- Your Benefits
- Required Proof Documents
- Important Notices

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

WHAT'S NEW THIS YEAR

- ❑ **Increasing the HMO IL plan's copays from: $20 PCP, $40 Specialist and $75 Emergency Room to $30 PCP, $50 Specialist and $125 Emergency Room**
- ❑ **Blue Choice Options PPO 500 plan is replacing the PPO 500**
- ❑ **Blue Choice Options PPO 750 is replacing the PPO 750**
- ❑ **Adding Blue Advantage HMO plan alongside HMO IL plan**
- ❑ **The HDHP deductible amounts are increasing from $1,600 to $1,700 for individuals and $3,000 to $3,400 for family (IRS Guidelines)**
- ❑ **Commuter Benefits**

ELIGIBILITY

Benefits Overview

Our goal is to provide you with the most comprehensive health benefits possible while remaining good stewards with our fiscal commitments and obligations.

We offer a well-rounded package consisting of:

- ❑ Medical Insurance
- ❑ Dental Insurance
- ❑ Life Insurance
- ❑ Accidental Death & Dismemberment (AD&D) Insurance
- ❑ Long-Term Disability (LTD)
- ❑ Wellness Program
- ❑ Flexible Spending Account (FSA)
- ❑ Employee Assistance Program (EAP)
- ❑ Commuter Benefits
- ❑ Supplemental Employee and Dependent Life and AD&D Insurance

Who Is Eligible?

Eligible employees are all full-time staff and part-time certified. The plan allows coverage for your legal spouse and/or child(ren) biological, adopted, step, covered from birth to age 26.

Eligible spouse or children may select the CCSD 62 Health Care Plan if they have access to group medical insurance coverage elsewhere.

Active eligible employees, regardless of age, are eligible for benefits under the CCSD 62 Health Plan.

Life Insurance and AD&D

CCSD 62 provides its eligible employees with Group Life and Accidental Death and Dismemberment Insurance (AD&D).

Features included in your Life coverage include a Right to Convert Provision, Waiver of Premium, which will continue Life coverage without payment of premium while you are Totally Disabled, an Accelerated Benefit for the terminally ill.

The Who's Who of Your CCSD 62 Medical Plans

- **Blue Cross and Blue Shield of Illinois** is the claims administrator for the BCO, HMO, and HDHP plans. They determine if you and your dependents are eligible for benefits and process your claims. Contact Blue Cross for questions concerning eligibility, plan benefits, or status of claim payments.
- **Blue Cross** BCO and HDHP Customer Service can be reached at **800.458.6024**, between 8:30 a.m. and 6:00 p.m., CST, Monday through Friday. Blue Cross HMO Customer Service can be reached at **800.892.2803**.
- **Blue Cross's Website** is user friendly and informative. You can locate doctors and hospitals participating in the network. The Blue Access site allows you to e-mail customer service with questions, check the status of a claim, print a medical claim form, print a temporary ID card and request a duplicate ID Card. You can also review the Blue 365 program, which offers discounts on vision care and other services. Their web address for members is **www.bcbsil.com**.
- **Blue Cross's BCO** (Blue Choice Options) is the network for the BCO and HDHP (high deductible health plan) plans. This means a group of select hospitals, clinics, physicians, and medical services that provide quality health care at a reduced rate. Contact Blue Cross to determine if your healthcare provider is part of the network. Call them at **800.458.6024** from 8:30 a.m. to 6:00 p.m., CST, Monday through Friday, or visit their website at **www.bcbsil.com**.
- **Blue Cross's Medical Services Advisory** is your utilization review contact. They work with your doctor to ensure you are getting the most appropriate care, in the appropriate setting for hospital stays. Contact them at **800.826.8551**, 7:00 a.m. to 7:00 p.m., CST, Monday through Friday.
- **Prime Therapeutics** is your Prescription Benefit Manager. Both the Retail and Mail Prescription Services are administered through Prime Therapeutics. Retail prescriptions can be obtained through participating pharmacies by presenting your Blue Cross ID Card. Mail program brochures can be obtained on the Blue Cross website **www.bcbsil.com**. You can also view the formulary program, locate a participating pharmacy, order refills, etc., on the website. If you have specific questions or issues, please call the Blue Cross Prescription Drug Inquiry Unit at **800.423.1973**.

To make a change to your medical or dental benefits or flexible spending account, you must experience a qualified life event in accordance with the Cafeteria Plan.

Health Care Dependent Enrollment Requirements

If you enroll dependents in the Health Care Plan, you are required to submit additional proof documentation with your enrollment. This year everyone enrolled in the medical plan, including spouses and children, will be required to submit their full social security number.

Your elections will be effective on January 1, 2025. You will not be permitted to change your election during the plan year unless you experience a **qualified life event.**

Coordination of benefits rules apply if you have dependents enrolled with other coverage.

Changing your benefits during the year

With the Cafeteria Plan, including employee contributions on a pre-tax basis and the FSA, it is important that you make your elections during your enrollment period carefully because you can only make changes during the year if you have a **qualified life event** according to IRS regulations listed below.

Changes to your Medical/Dental, Flexible Spending Account can be made if preceded by a **documented qualified life event** and they are made within 31 days of the event. Your change must be consistent with your life event/status change. The following events qualify for a change in coverage:

- ❑ Marriage
- ❑ Civil Union
- ❑ Divorce or legal separation
- ❑ Birth or placement for adoption of a child
- ❑ Death of a dependent
- ❑ Ineligibility of a dependent
- ❑ Loss of other coverage
- ❑ Change in your employment status or that of your spouse
- ❑ Significant change in health coverage attributable to your employment or that of your spouse
- ❑ A court order
- ❑ Entitlement to Medicare or Medicaid

If you experience one of these events and want to change your benefits, you must make the change within 31 days after the event occurs. Changes cannot be made before the event occurs. If you miss the window for making a change, you can make an election during an open enrollment period.

If you experience one of these events and want to change your benefits or have any questions, please contact Julie Salmons Hubbard via phone **847.824.1185**, or by email, **salmonshubbardj@d62.org**.

DEPENDENT VERIFICATION DOCUMENTATION

If you are enrolling dependents in the Healthcare Plan, dependent eligibility documentation is required.

Spouse

- Marriage certificate
- Civil Union certificate
- Domestic Partner Affidavit

Biological Child

- One of the following:
  - » Birth certificate of biological child
  - » Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old

Adopted Child

- One of the following:
  - » Official court/agency papers (initial stage)
  - » Official Court Adoption Agreement (mid-stage)
  - » Birth certificate (final stage)

Stepchild

- Child's Birth Certificate showing the child's parent is the employee's legal spouse/civil union partner
- Certificate showing legal marriage/ civil union between the employee and the child's parent

Guardianship

- Court papers demonstrating legal guardianship, including the person named as legal guardian

Court-Ordered Medical Coverage

- One of the following:
  - » Qualified Medical Child Support Order (QMCSO)
  - » National Medical Support Notice (NMSN)

Child Age 26 or Older

- Certified Handicapped Child/ Disabled Student Attending Physician Statement signed by the employee and the child's attending physician
- DD-214 military documents showing honorable discharge from military branches

Maximize Your Benefits

The following are helpful hints designed to help you get the most out of your health plans.

Using the Blue Cross and Blue Shield of Illinois BCO and HDHP Network Services

Before going to a Blue Cross hospital, call Blue Cross's BCO and HDHP info line at **800.458.6024** or visit their website **www.bcbsil.com** to ensure the hospital is part of the network.

Present your insurance ID card to your healthcare provider at your appointment. This informs providers where they need to send your claims and identifies you as a Blue Cross member.

Blue Cross participating providers will forward claims directly to Blue Cross before requesting any necessary deductible or coinsurance payments from you so the appropriate discount can be applied. An office copay may be required.

Hospital Precertification Program for the CCSD 62 Plan

You, your doctor, or a family member must call Medical Services Advisory for any hospital stay. You must call 72 hours (3 days) before a planned hospital admission or the next business day after an emergency or maternity admission. *If you fail to precertify your stay, it will result in a $500 penalty!* **Medical Services Advisory can be reached at 800.826.8551.**

PPO Plan Tips!

- ❑ Before going to a doctor or hospital visit the BCBS website at **www.bcbsil.com** or call Blue Cross to ensure the provider or facility is part of the network.
- ❑ Present your insurance ID card to your healthcare provider at your appointment to ensure they send your claims to Blue Cross for processing.
- ❑ Blue Cross participating providers will forward claims directly to Blue Cross for processing. They will typically not request any deductible or coinsurance payments from you prior to submitting the claim to Blue Cross so the appropriate discount can be applied. An office copay may be required at time of service.

HMO Plan Tips!

- ❑ Make sure you have chosen a Medical Group for each person on your policy and the Medical Group appears on your ID Card.
- ❑ You can change Medical Groups at any time and it will be effective the first of the following month.
- ❑ Get three months of maintenance medications at retail for two copays. You can save 4 copays annually!!
- ❑ In situations when you need immediate medical services but don't want to pay the high emergency room copay call your provider. Most Medical Groups have after hour clinics near by and it will only cost you an office visit copay.

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one **Plan**.

The order of benefit determination rules govern the order in which each **plan** will pay a claim for benefits. The **plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **plan** may cover some expenses. The **plan** that pays after the **Primary plan** is the **Secondary plan**.

If the plan is secondary, the total payment from all plans cannot be more than what it would normally pay in benefits if it was the primary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense. In addition, if the plan is Secondary, it will pay for expenses only covered by our plan. If the other Primary plan covers a service that we do not cover, we will not coordinate benefits on that particular expense.

If the employee is married to a spouse that has group medical insurance elsewhere and the couple has children, the parent whose birthday month and day falls before the others will provide the Primary plan for the children and the parent whose birthday month and day falls after will provide the Secondary plan. The District's plan is the Primary plan for all active employees.

Predetermination: Members are encouraged to always obtain prior approval when using non-network providers. Predetermination will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

BCBS Health Care Plan Administrator

Blue Cross Blue Shield continues to be our health care provider. As always, you can go to their website **www.bc**
to the single tier. Family deductible and out-of-pocket pertains to the employee+spouse, employee+child(ren), a

	HMO Illinois	Blue Advantage HMO	Blue Choice Option PPO 500		
	HMO Illinois Network	**Blue Advantage HMO Network**	**BCO In-Network**	**PPO In-Network**	**Out-of-Network**
Lifetime Maximum	Unlimited	Unlimited	Unlimited		
Deductible[1]					
Individual	N/A	N/A	$500		$1,500
Family	N/A	N/A	$1,500		$3,000
Coinsurance	100%	100%	90%	80%	70%
Out-of-Pocket Limit[1]					
Individual	$1,500	$1,500	$2,000[3]	$2,500[3]	$3,000
Family	$3,000	$3,000	$4,000[3]	$5,000[3]	$6,000
Covered Expenses					
Hospital					
Inpatient Services	100%	100%	90%*	80%*	70%*
Outpatient Services	100%	100%	90%*	80%*	70%*
Emergency Room	$125 copay; Copay waived if admitted	$125 copay; Copay waived if admitted	$125 copay then 90%*; copay waived if admitted		
Physician					
Inpatient Surgery	100%	100%	90%*	80%*	70%*
Outpatient Surgery	100%	100%	90%*	80%*	70%*
Primary Care Visits	$30 copay[2]	$30 copay[2]	$30 copay[2]	$30 copay[2]	70%*
Specialist Visits	$50 copay[2]	$50 copay[2]	$50 copay[2]	$50 copay[2]	70%*
Wellcare/Physical Exam[4]	100%	100%	100%	100%	70%*
MDLive Virtual Visits	Not Available	Not Available	$30 copay[2]	$30 copay[2]	N/A
Other					
X-ray and Lab	100%	100%	90%*	80%*	70%*
Chiropractic	$30 copay[2]; PCP referral required	$30 copay[2]; PCP referral required	90%*	80%*	70%*
Therapy: Occupational, Physical or Speech[1]	$30 copay[2]; PCP referral required. 60 visits combined limit for all therapies.	$30 copay[2]; PCP referral required. 60 visits combined limit for all therapies.	90%*	80%*	70%*
Prescription Drugs					
Retail Pharmacy[2]	$10 Generic $35 Formulary Brand $60 Non-Formulary Brand	$10 Generic $35 Formulary Brand $60 Non-Formulary Brand	$10 Generic, $35 Formulary Brand, $60 Non-Formulary Brand		
Mail Order[2]	$20 Generic $70 Formulary Brand $120 Non-Formulary Brand	$20 Generic $70 Formulary Brand $120 Non-Formulary Brand	$20 Generic, $70 Formulary Brand, $120 Non-Formulary Brand		
Prescription Out-of-Pocket Limit (Single / Family)	$1,000 / $2,000	$1,000 / $2,000	$1,000 / $2,000		
Vision Benefit	Vision exam every 12 months; $150 contact lens allowance every 24 months; $225 frame allowance every 24 months	Vision exam every 12 months; $150 contact lens allowance every 24 months; $225 frame allowance every 24 months	$30 allowance towards vision exam every 12 months; $200 materials allowance every 12 months		Not Covered

1. Deductibles, Out-of-Pocket, Chiropractic, and Therapy limits are based on calendar year.
2. Copays are applied towards the out-of-pocket limit. Copays are not applied towards the deductible. Copays apply only to office visit charge, not to misc. expense incurred during visit.
3. Out-of-pocket limits for BCO In-Network and PPO In-Network cross apply. They are not separate buckets.
4. Applies to both adults and children, as defined by the US preventive task force.
5. If you are covering dependents and enrolled in the HDHP plan, please note: once a family member meets the individual out-of-pocket limit, coinsurance benefits begin for that individual. No individual will contribute more than the individual out-of-pocket amount to the family out-of-pocket amount.

*Subject to deductible and coinsurance

cbsil.com to learn more. Individual deductible and out-of-pocket pertains and family tiers

Blue Choice Option PPO 750			HDHP 1700	
BCO In-Network	**PPO In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Unlimited			Unlimited	
$750		$1,500	$1,700	
$2,100		$4,200	$3,400	
90%	80%	70%	90%	70%
$2,500[3]	$3,000[3]	$4,500	$5,950[5]	
$5,000[3]	$6,000[3]	$9,000	$7,150[5]	
90%*	80%*	70%*	90%*	70%*
90%*	80%*	70%*	90%*	70%*
$125 copay then 90%*; copay waived if admitted			90%*	
90%*	80%*	70%*	90%*	70%*
90%*	80%*	70%*	90%*	70%*
$30 copay	$30 copay	70%*	90%*	70%*
$50 copay	$50 copay	70%*	90%*	70%*
100%	100%	70%*	100%	70%*
$30 copay	$30 copay	N/A	90%*	N/A
90%*	80%*	70%*	90%*	70%*
90%*	80%*	70%*	90%* 30 visits per calendar year	70%* 30 visits per calendar year
90%*	80%*	70%*	90%*	70%*
$10 Generic. $35 Formulary Brand, $60 Non-Formulary Brand			90%*	
$20 Generic, $70 Formulary Brand, $120 Non-Formulary Brand			90%*	
$1,000 / $2,000			Combined with Medical	
$30 allowance towards vision exam every 12 months; $200 materials allowance every 12 months		Not Covered	Not covered	

Note: The Comparisons are outlines of the benefit schedules. This exhibit in no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operation of the plans.

Choosing the plan that's right for you

When deciding what medical insurance plan is right for you and your family there are a number of factors you should take into consideration. Most people will choose a plan based on paycheck deduction amount, deductible, coinsurance and provider network.

The right plan for you includes:

- Per paycheck deduction that meets your budget
- Out-of-pocket cost that you can afford when medical care and prescriptions are needed (e.g., deductible, coinsurance, copays, etc.)
- Your doctors and hospitals in the network
- The benefits you need, i.e., infertility, chiropractic, acupuncture, etc.

BlueCross BlueShield of Illinois

Health care at your fingertips.

Blue Cross and Blue Shield of Illinois (BCBSIL) helps you get the most from your health care benefits with Blue Access for Members (BAM℠). You and all covered dependents age 18 and up can create a BAM account.

With BAM, you can:

- Find care – search for in-network doctors, hospitals, pharmacies and other health care providers
- Get your digital member ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Sign up for text or email alerts

It's easy to get started.

Use your member ID card to create a BAM account at **bcbsil.com**, or text* **BCBSILAPP** to **33633** to download our mobile app.

SCAN ME

Scan this QR code to visit bcbsil.com.

BlueCross BlueShield of Illinois

Download the Blue Cross and Blue Shield of Illinois (BCBSIL) App to manage your health wherever you are.

- Find an in-network doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View or print your member ID card
- Log in securely with your fingerprint or face recognition*
- View your Explanation of Benefits

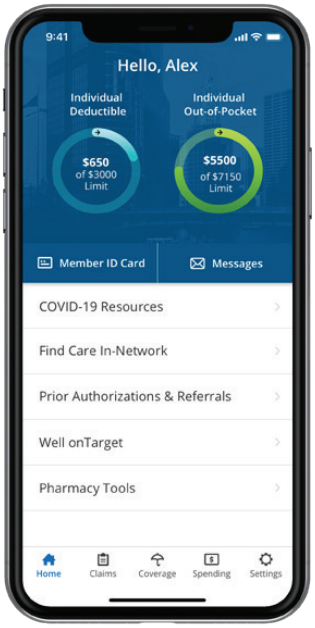
Then, Manage Your Preferences

In the BCBSIL App:

- Update your profile with your mobile number.
- Set your notification preferences to text.

Choose the messages and information you want to get:

- Claims, prior authorization or referral updates
- New documents to review
- Secure message notifications
- Find out about new benefits and services



Available in Spanish

Ready to get started? Text **BCBSILAPP** to **33633**** to get the app.

Download on the App Store

GET IT ON Google Play

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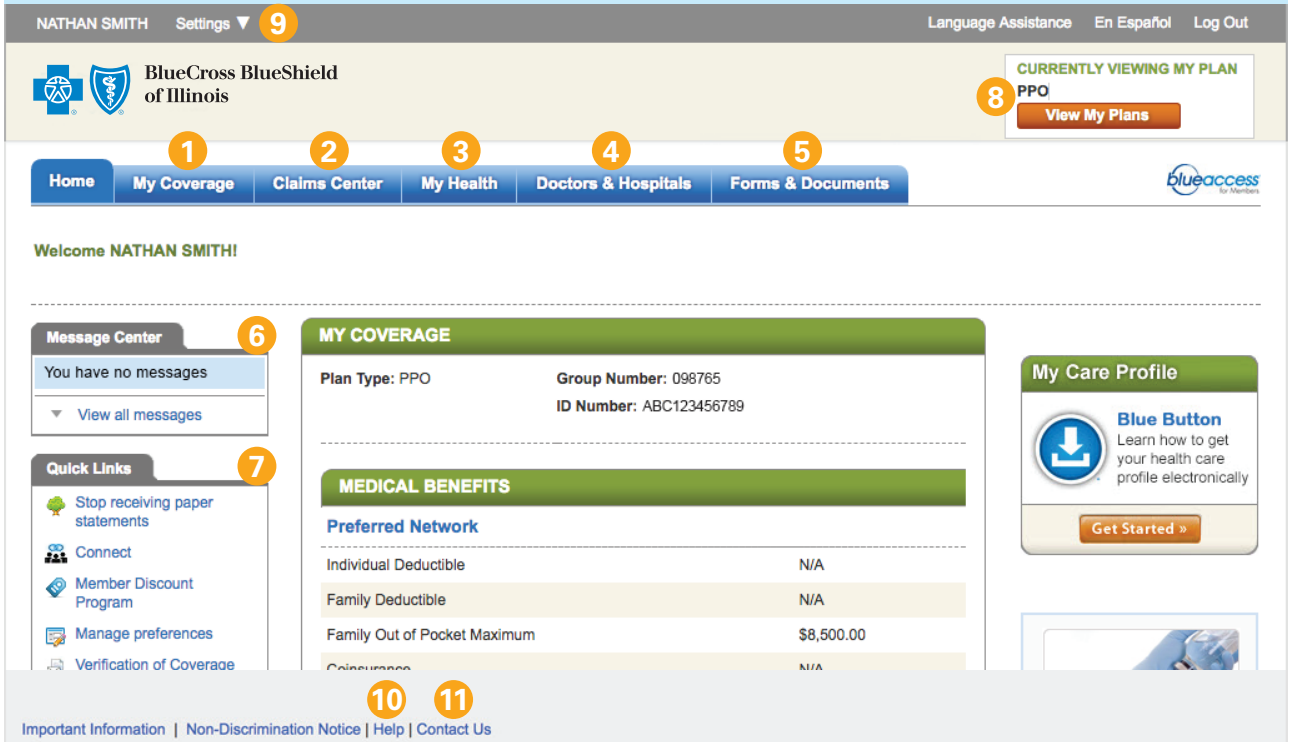
Find what you need with Blue Access for Members



1. **My Coverage:** Review benefit details for you and family members covered under your plan.
2. **Claims Center:** View and organize details such as payments, dates of service, provider names, claims status and more.
3. **My Health:** Make more informed health care decisions by reading about health and wellness topics and researching specific conditions.
4. **Doctors & Hospitals:** Use Provider Finder® to locate a network doctor, hospital or other health care provider, and get driving directions.
5. **Forms & Documents:** Use the form finder to get medical, dental, pharmacy and other forms quickly and easily.
6. **Message Center:** Communicate with a Customer Service Advocate here. You can also learn about updates to your benefit plan and receive promotional information via secure messaging.
7. **Quick Links:** Go directly to some of the most popular pages, such as medical coverage, replacement ID cards, manage preferences and more.
8. **View My Plan:** See the details of your current health plan, as well as other plans you've had in the past.
9. **Settings:** Set up notifications and alerts to receive updates via text and email, review your member information and change your secure password at anytime.
10. **Help:** Look up definitions of health insurance terms, get answers to frequently asked questions and find Health Care School articles and videos.
11. **Contact Us:** Here you can find contact information to reach a Customer Service Advocate with any questions you may have about your plan.

BLUE CROSS BLUE SHIELD RESOURCES

BlueCross BlueShield of Illinois

It's now easier to find a provider and manage health care expenses.

Provider Finder from Blue Cross and Blue Shield of Illinois (BCBSIL) is a fast, easy-to-use tool that improves members' experience when they're looking for in-network health care providers. Plus, it can help them manage their out-of-pocket costs.

The updated Provider Finder platform has undergone intensive testing. The result is a better experience that will help members be smarter consumers of health care.

By going to **bcbsil.com**, members can login or create an account on Blue Access for Members℠ (BAM℠) and use Provider Finder to:

- Find in-network providers, clinics, hospitals and pharmacies.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Compare quality awards for doctors, hospitals and more.
- Read or add reviews for providers.
- Estimate the out-of-pocket costs for more than 1,700 health care procedures, treatments and tests.*
- Find cost savings opportunities using the Medication Finder tool.

Go Mobile with BCBSIL

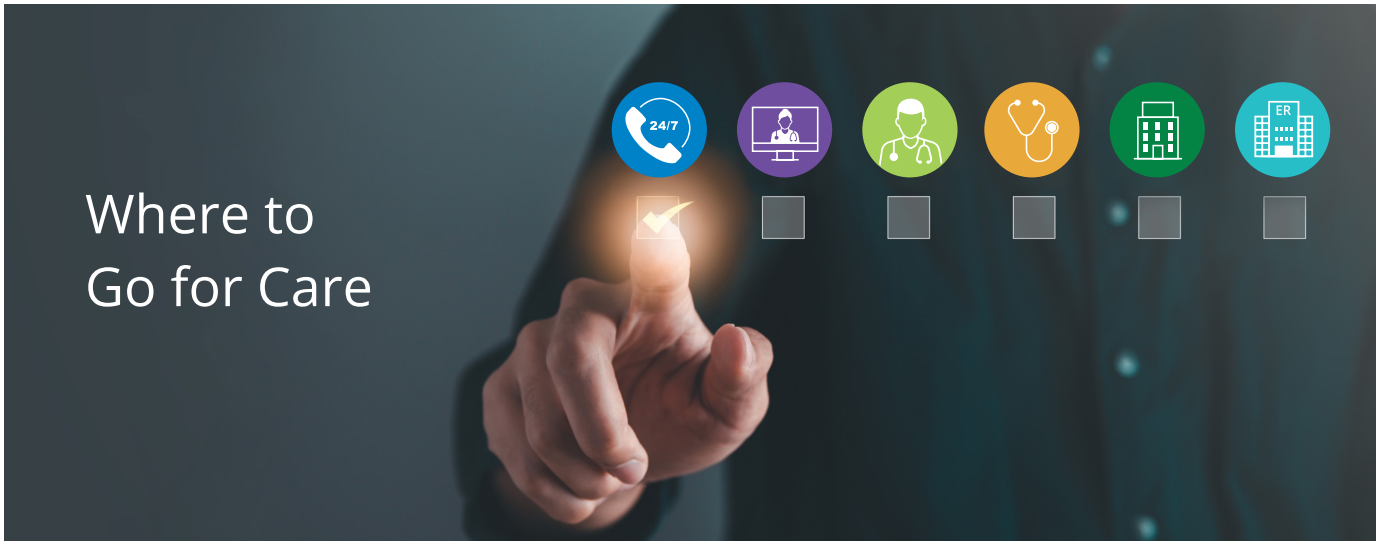
Even on the go members can manage their ID cards and stay on top claims activity, coverage information and prescription refill reminders. It's easy: Log into or create a BAM account at **bcbsil.com** or text BCBSIL to 33633** to download our mobile app.

* Not all plans provide this information.

** Message and data rates may apply. Terms and conditions and privacy policy are available at bcbsil.com/mobile/text-messaging.

PPO AND HDHP MEMBERS ONLY

BlueCross BlueShield of Illinois



Where to Go for Care

What do you do if your clutch player breaks an arm in the big game? Or you slice your finger chopping veggies? Or have stomach cramps after last night's sushi date? Often the choice is clear. If you have signs of a heart attack, it's best to go to the emergency room. But what if you have a sore throat? Or lower back pain?

Knowing where to go can make a big difference in the cost of your care – especially when you use in-network providers.

We make it easy to find independently contracted, in-network providers near you:

- Go to **bcbsil.com** and click **Find Care**
- For personalized search results, go to **bcbsil.com**, click **Log In or Sign Up**, choose **Member Log In or Sign Up** and search in Blue Access for Members℠
- Call BCBSIL Customer Service at the number on your ID card

24/7 Nurseline[1]

Wonder if your heartburn needs an antacid or trip to the ER? Is your kiddo's fever 102? Confused about a health test? Talk confidentially with a registered nurse in English or Spanish – anytime. Call **800-299-0274**.

Good for: health questions and health advice
Average Wait: none
Cost: none

Virtual Visits[2]

Got an itchy rash? Sinuses stopped up? Fighting a fever? Talk with a doctor – 24/7. Online appointments via MDLIVE® put care at your fingertips. Call **888-676-4204** or go to **MDLIVE.com/bcbsil**.

Good for: health exams, colds, flu, minor injuries
Average Wait: less than 20 minutes
Cost: in network **$**

PPO AND HDHP MEMBERS ONLY

CCSD 62

Doctor

Is your blood pressure high? Are allergies making you miserable? Can't sleep? Your go-to provider is a good place to start. Some even offer telemedicine. If you need a specialist, your doctor will tell you.

Good for: health exams, shots, cough, sore throat
Average Wait: less than 20 minutes[3]
Cost: in network **$** out of network **$$**

Retail Health Clinic

Need a flu shot? Feel queasy? Have an earache or rash? Many grocery stores and pharmacies have on-site medical clinics. Some may even see patients evenings, weekends and holidays.

Good for: headache, stomach ache, sinus pain
Average Wait: variable
Cost: in network **$** out of network **$$**

Urgent Care Center[4]

Sprain your ankle? Have a monster migraine? Can't stop coughing? Need non-emergency care right away, but your doctor's office isn't open? These centers offer care evenings, weekends and holidays.

Good for: back pain, vomiting, animal bite, asthma
Average Wait: 30 minutes or less[5]
Cost: in network **$$** out of network **$$$**

Hospital ER

Worried you may be having a heart attack? Did you black out after a nasty fall? ER doctors and staff treat serious and life-threatening health issues 24/7. If you receive ER care from an out-of-network provider, you may have to pay more.

Good for: chest pain, bleeding, broken bones
Average Wait: 1 hour or more[6]
Cost: in network **$$$** out of network **$$$$**

Know the Difference: Freestanding ER vs. Urgent Care Center

Freestanding ERs look a lot like urgent care centers, but may not be affiliated with an in-network hospital. That means you could end up with a hefty bill (or several bills). You might even be sent to a hospital ER for care! Here are ways to spot a freestanding ER:

1. Look for "Emergency" on the building exterior.
2. Check the hours. If it's open 24/7, it's a freestanding ER. Urgent care centers close at night.
3. Confirm it's not connected to a hospital.
4. Ask if it follows the copay, coinsurance and deductible payment model.

If you need emergency care, call 911 or seek help from any doctor or hospital immediately.

Note: Many sites of care now offer telehealth options for your visit. Check with your preferred provider to see if they offer telehealth visits.

1. 24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.
2. Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.
   MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Illinois. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.
3. Vitals Annual Wait Time Report, 2017.
4. The closest urgent care center may not be in your network. Be sure to check Provider Finder® to make sure the center you go to is in-network.
5. Wait Time Trends in Urgent Care and Their Impact on Patient Satisfaction, 2017.
6. National Center for Health Statistics, Centers for Disease Control and Prevention, 2019.

Information provided in this flier is not intended as medical advice, nor meant to be a substitute for the individual medical judgment of a doctor or other health care professional. Please check with your doctor for individualized advice on the information provided. Coverage may vary depending on your specific benefit plan and use of network providers. For questions, please call the number on your member ID card.

WONDR HEALTH FOR PPO / HDHP / HMO MEMBERS

Clinically-proven weight loss without counting calories

Now you can lose weight, gain energy, sleep better, and improve your mind and body—all while eating your favorite foods.

Your employer has partnered with Wondr Health™ to help you improve your health at no cost to you.*

Go to wondrhealth.com/BCBSIL

What is Wondr?

No points, plans, or counting calories. Forget eating kale salads 24/7; Wondr is a skills-based digital weight loss program that teaches you how to enjoy the foods you love to improve your overall health. Our behavioral science-based program was created by a team of doctors and clinicians (which is why we left out the "e" in Wond**r**) and is clinically-proven for lasting results.

*To learn more and join the waitlist, visit: wondrhealth.com/BCBSIL

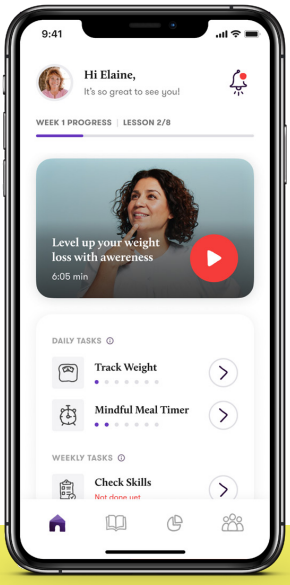
Questions? Visit support.wondrhealth.com

LET'S TALK RESULTS

In as little as 10 weeks:

- **84%** LOST WEIGHT
- **62%** FEEL MORE CONFIDENT
- **61%** HAVE MORE ENERGY
- **85%** FEEL MORE IN CONTROL OF THEIR WEIGHT
- **68%** ARE MORE PHYSICALLY ACTIVE
- **57%** FEEL THEIR MOOD HAS IMPROVED

*Based on Wondr Health Book of Business



"I love the whole idea of the psychology of things. I like to look in the why's and how it works. You can eat whatever you want. You just need to retrain your brain into thinking about how you need to eat your food."

—Brad M.
WONDR PARTICIPANT

LOST 70 lbs | **GAINED Confidence**

GET IT ON Google Play

Download on the App Store

wondr | FORMERLY NATURALLY SLIM

BCBSIL LEARN TO LIVE
PPO AND HDHP MEMBERS ONLY

CCSD 62

BlueCross BlueShield of Illinois

See how much better life can feel with digital mental health programs from Learn to Live.[1]

More than half of people will struggle with a mental health concern at some point in their lives.[2] But you can learn new skills to break old patterns that may be holding you back. Digital mental health programs from Learn to Live can help you get your mental health on track so you can feel better and enjoy life more.

Find out where you may need support

An online assessment helps pinpoint the right programs for you, such as:

- Stress, anxiety and worry
- Depression
- Insomnia
- Social anxiety
- Substance use
- Panic
- Resiliency

learntolive

BCBSIL LEARN TO LIVE
PPO AND HDHP MEMBERS ONLY

Get a mental health tune-up — online

Learn to adjust unhelpful thoughts and control your moods

Explore quick and easy lessons whenever it fits your schedule. A little homework between sessions helps you keep up your progress. Activities are based on therapy techniques with a track record of helping people get better.

An expert coach can guide you

If you need one-on-one support to reach your goals, connect with a coach by phone, text or email. They'll lift you up, cheer you on and help you master your new skills.

Your personal details are private

Just like with face-to-face therapy, your personal results, program progress and messages with your coach will not be shared with your employer.

Check out the programs included at no added cost through your Blue Cross and Blue Shield of Illinois (BCBSIL) plan:

1. Log in at **bcbsil.com**.
2. Click **Wellness**.
3. Choose **Digital Mental Health**.

Or tap **Digital Mental Health** in the BCBSIL App.

Register a Minor

BCBSIL members 13 to 17 years old can also use the programs. Once you've logged in to Learn to Live using the steps above, go the **Resources** tab. Then find the **Register a Minor** link to send your teen a registration email.

1. Learn to Live provides educational behavioral health programs; members considering further medical treatment should consult with a physician.
2. https://www.cdc.gov/mentalhealth/learn/index.htm

Learn to Live, Inc. is an independent company that provides online behavioral health programs and tools for members with coverage through Blue Cross and Blue Shield of Illinois. BCBSIL makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

243126.0722

ovia health™

access your maternity and family benefit

Ovia Health™ offers support for reproductive health, starting a family, having a healthy pregnancy, balancing life as a parent and managing menopause. Ovia Health apps are included in your health plan benefits, offered through Blue Cross and Blue Shield of Illinois (BCBSIL).

ovia®
Support for reproductive health, fertility and menopause

ovia® pregnancy
Ongoing support for your healthiest, happiest pregnancy

ovia™ parenting
Go to resource for family & working parents

To start receiving support:

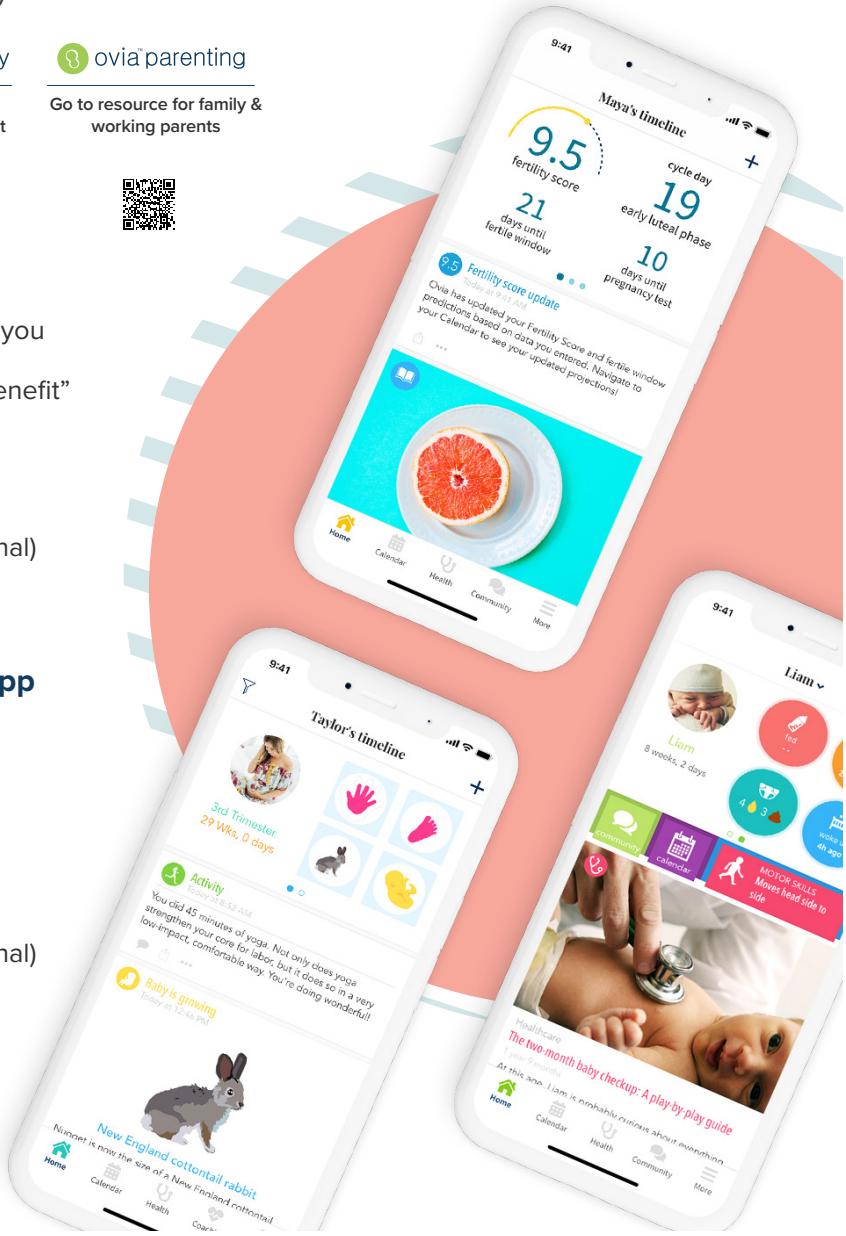
1. Download the app that's right for you
2. Select "I have Ovia Health as a benefit" during signup
3. Enter your health plan
4. Enter your employer name (optional)
5. Explore Ovia Health!

Already have an Ovia Health app on your phone?

1. Open the "more" menu
2. Tap "My healthcare info"
3. Enter your health plan
4. Enter your employer name (optional)

Download on the App Store | ANDROID APP ON Google play

ES | Ovia Apps are available in Spanish



PRIME THERAPEUTICS RESOURCES

Prime Therapeutics offers many options, resources and advantages as the pharmacy benefits manager through BCBSIL.

- ❑ Cost savings: Using generic drugs, when right for you, can help you save money. If you are taking or are prescribed a brand drug, visit **bcbsil.com** or **myprime.com** to find out if generic options are available.
- ❑ Convenience: A broad pharmacy network allows you to choose a contracting retail pharmacy close to you.
- ❑ Time savings: Through mail service, you can have maintenance medications delivered directly to you.
- ❑ Safety programs: BCBSIL has programs that help identify potential safety concerns.

In your Blue Access for Members (BAM) portal click prescription drugs in the quick links box on the right. This will take you to **myprime.com**, the member site of BCBS pharmacy benefit manager.

At **myprime.com** you will find a variety of tools that can help you learn more about your medication, estimate prescription drug costs and help you better communicate with your doctor about your prescription medication options.

Use **myprime.com** to:

- ❑ Find out if a drug is on your plan's formulary. Using formulary drugs usually costs you less.
- ❑ See a list of generic options for a brand medication and learn more about generic drugs. Using generic drugs can save you money.
- ❑ Calculate your estimated cost for a 30-day or 90-day supply of a covered medication.

MDLive Virtual Visits for PPO and HDHP Members

What is it?

Blue Cross and Blue Shield of Illinois (BCBSIL) provides members and covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE Virtual Visits. This means that you and your dependents can connect with a doctor using your mobile device, computer or telephone from the convenience of your home 24/7.

Why would I use it?

Getting sick is never convenient and finding time to get to the doctor can be hard. Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits may also be a better alternative for non-emergency conditions than going to the emergency room or urgent care center.[1]

MDLIVE doctors or therapists can help treat the following conditions and more:

❑ General Health
- Allergies
- Asthma
- Sinus infections

❑ Pediatric Care
- Flu
- Ear problems
- Pink Eye

❑ Behavioral Health
- Anxiety / Depression
- Child Behavior
- Marriage problems

What is the cost?

❑ PPO members medical and behavioral health visits are a $20 copay per visit.

❑ HDHP members medical visits cost $44/visit on average until the deductible is met and then coinsurance applies. A behavioral health visit cost can vary. Contact BCBSIL Customer Service for further information.

How do I access Virtual Visits?

You can connect to MDLive Virtual Visits online, on your mobile device or by telephone. Once you are connected, you can consult with a board-certified doctor or therapist. If prescriptions are warranted, they can be sent electronically to a pharmacy of your choice.

Connect

Computer, smartphone, tablet or telephone

Website: Visit the website **MDLIVE.com/bcbsil**

❑ Choose a doctor
❑ Video chat with the doctor
❑ You can also access through Blue Access for Members℠

Interact

Real-time consultation with a board-certified doctor or therapist

Mobile app:

❑ Download the **MDLIVE** app
❑ Open the app and choose an **MDLIVE** doctor
❑ Chat with the doctor from your mobile device

Diagnose

Prescriptions sent electronically to a pharmacy of your choice (when appropriate)

Telephone:

❑ Call **MDLIVE (888.676.4204)**
❑ Speak with a health service specialist
❑ Speak with a doctor

MDLIVE, an independent company, provides virtual visit services for Blue Cross and Blue Shield of Illinois. MDLIVE operates and administers the virtual visit program and is solely responsible for its operations and that of its contracted providers.

[1] In the event of an emergency, this service should not take the place of an emergency room or urgent care center. MDLIVE doctors do not take the place of your primary care doctor. Proper diagnosis should come from your doctor, and medical advice is always between you and your doctor. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

Blue Distinction: For hospitals with expertise in specialty care

Blue Distinction is a designation awarded by the Blue Cross and Blue Shield companies to hospitals that have demonstrated expertise in delivering clinically proven specialty health care. Its goal is to help consumers find specialty care on a consistent basis, while enabling and encouraging health care professionals to improve the overall quality and delivery of care nationwide.

Use the Blue Distinction Center Finder.

- ❑ Go to **bcbsil.com**
- ❑ Select the Provider Finder® tool and search for hospitals
- ❑ To find a Blue Distinction center near you, search by designated area of specialty and state

Here are some examples of the Centers of Excellence available to you.

Blue Distinction Centers for Bariatric Surgery®

Provides a full range of bariatric surgical care services, including inpatient care, post-operative care, follow-up and patient education.

Blue Distinction Centers for Cardiac Care®

Provides a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery.

Blue Distinction Centers for Transplants®

Transplant program that provides services, such as global pricing, financial savings analysis, and global claims administration and support services.

Blue Distinction Centers for Complex and Rare Cancers®

Inpatient cancer care programs for adults, including those treating complex and rare subtypes of cancer, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise, focus on treatment planning and complex, major surgical treatments.

Blue Distinction Centers for Knee and Hip Replacement℠

Provides inpatient knee and hip replacement services, including total knee and total hip replacement surgeries.

Blue Distinction Centers for Spine Surgery®

Inpatient spine surgery services, including discectomy, fusion and decompression procedures.

BlueCross BlueShield of Illinois

24/7 Nurseline

Nurses available anytime you need them.

Health happens – good or bad, 24 hours a day, seven days a week. That is why we have registered nurses waiting to talk to you whenever you call our 24/7 Nurseline*.

Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever
- Sore throat
- Diabetes
- A baby's nonstop crying
- And much more

Plus when you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish.

So, put the 24/7 Nurseline phone number in your contacts today, because health happens 24/7.

Call 800-299-0274 to reach the 24/7 Nurseline and talk to a nurse. Hours of Operation: Anytime

*24/7 Nurseline is not available to HMO members. For medical emergencies, call 911.
This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

9100083.0520

Women and Family Health Pregnancy and Parenting Support® for PPO and HDHP Members

This program can help you better understand and manage your pregnancy. Available at no additional cost, this maternity program supports you from early pregnancy and after delivery:

- ❑ Pregnancy risk factor identification to determine the risk level of your pregnancy and appropriate range for ongoing communication/monitoring.
- ❑ Educational material including a complimentary book about having a healthy pregnancy and baby.
- ❑ Personal telephone contact with program staff to address your needs and concerns and to coordinate care with your physician.
- ❑ Assistance in managing high-risk conditions such as gestational diabetes and preeclampsia.
- ❑ Ovia Health Apps are for tracking your cycle, pregnancy and baby's growth.

The site can be accessed through Blue Access for Members℠. Download any of the Ovia Health mobile apps from the Apple App Store or Google Play. During sign up, make sure to choose "I have Ovia Health as a benefit." Then select BCBSIL as your health plan.

Enrollment is easy and confidential. Just call **855.705.7279**, 8 a.m. – 6:30 p.m., CT.

Blue Care Connection

Blue Cross offers the following programs through Blue Care Connection, a program to help you and your covered family members reach your health and wellness goals.

Condition Management

Blue Care Advisors, registered nurses or other health care professionals, may contact you if you have certain health challenges or chronic conditions. Through regularly scheduled health counseling and coaching telephone calls, the advisor can help you identify unhealthy behaviors, set wellness goals, adopt healthier habits and learn to manage medical conditions more effectively.

The Condition Management programs are voluntary and work together with you, your health plan and your doctor to help identify the best ways to manage your chronic health condition and stay healthy.

When you enroll, you will have access to the best knowledge, tools and self-care techniques to help you make a difference in your health.

Following nationally recognized practice guidelines, the Condition Management programs specifically target:

- ❑ Asthma
- ❑ Chronic obstructive pulmonary disease (COPD)
- ❑ Congestive heart failure (CHF)
- ❑ Coronary artery disease (CAD)
- ❑ Diabetes

To enroll in a Condition Management program, or to find out how one of the programs can help you, please call the Customer Service number on the back of your member ID card.

Lifestyle Management

According to the Centers for Disease Control and Prevention (CDC) some of the most common harmful but modifiable behaviors are tobacco use, insufficient physical activity and poor eating habits. These lifestyle factors are responsible for much of the illness, disability and premature death related to chronic diseases. Blue Cross' Lifestyle Management programs address the key contributing factors to significant medical spending by focusing on **weight management, tobacco cessation and metabolic syndrome**. These programs help you to change your behavior by providing guidance and support through personal telephonic motivational coaching, self-directed online courses and weight management resource. To enroll in one of the Lifestyle Management programs please call the Customer Service number on the back of your member ID card.

CCEI Care Coordination and Early Intervention

CCEI is a program designed to help you get the care you need to stay healthier. If you are in the hospital or recently visited the emergency room, a care management specialist may call to help coordinate special care you might need.

The care management specialist will work with you to make sure that you have what you need to care for yourself and follow your doctor's instructions. There is no additional cost for this service and it is up to you if want to participate.

Care management specialists can:

- ❑ Help you understand your condition and treatment
- ❑ Include you in the decision making process
- ❑ Make sure you get the care your doctor recommends
- ❑ Explain your health care benefits

Case Management

A serious medical condition or injury can affect anyone. The support required for recovery or to manage disease progression is readily available through our innovative Case Management program. Blue Cross works to engage members in the Case Management program and provide interventions that support cost-effective care. Case managers, registered nurses with specialized training and clinical experience, help you to navigate complex medical situations and access the services you need.

The individualized approach features:

- ❑ **Episodic Case Management –** Monitors and coordinates transition to all levels of care including acute rehabilitation, skilled nursing facilities, long-term acute care, sub-acute and home settings.
- ❑ **Catastrophic/Complex Case Management –** Care coordination focused on members with late stage chronic conditions, serious illness or injuries such as:
  - Cancer
  - End stage renal disease
  - High-risk pregnancies
  - Infectious diseases
  - Major trauma
  - Premature births and birth defects
  - Rare diseases
  - Transplants
- ❑ **End of Life Care Program –** Facilitates appropriate treatment and helps members to maximize their benefits. This program addresses emotional and psychosocial issues, as well as pain and symptom management.

Getting involved early allows Blue Cross to work with you, your family and your doctor to coordinate an optimal plan of care that supports your needs and promotes quality, cost-effective outcomes.

Well onTarget®

When you feel well, you do well. But wellness involves more than just encouraging a sensible diet and exercise. That's why BCBS developed Well onTarget, an innovative solution that promotes good health across your entire organization, offering personalized initiatives no matter where you are on your wellness journey.

Well onTarget features include:

❑ **Member Wellness Portal –** A comprehensive, adaptable online portal that engages you through useful health resources, goal trackers, tools and more:

- Onmyway Health Assessment – Answer survey questions that assess their current health status. The results help identify health risks and define a personalized program with individual wellness goals.
- Health and Wellness Content – Online health encyclopedia that educates and empowers through evidence-based, consumer-friendly content.
- Onmytime Self-directed Courses – A suite of structured courses to help achieve health and wellness goals. Topics include nutrition, exercise, weight and stress management and tobacco cessation. Reach your milestones and earn Life Points.
- Tools and trackers- Interactive tools help keep you on course while making wellness fun. Use a food and exercise diary, symptom checker and health trackers.
- Life Points – A rewards program that reinforces positive lifestyle changes, such as more time at the gym or healthier meal choices.

❑ **Onmyteam Wellness Coaching –** Professionally certified coaches counsel employees on nutrition, physical activity and stress management, fostering sustained involvement through phone contact or secured messaging via the interactive member portal.

❑ **Fitness Program –** Fitness can be easy, fun and affordable. The Fitness Program is a flexible membership program. Gain unlimited access to a nationwide network of fitness centers. With more than 8,000 gyms on hand, you can work out at any place or at any time. Choose a gym close to home and one near your office.

- No long-term contracts required. Membership is month to month. Monthly fees are $25 per month per member, with a one-time enrollment fee of $25
- Automatic withdrawal of monthly fee
- Online tools for locating gyms and tracking visits
- Earn 2,500 bonus Life points for joining the Fitness Program and up to 500 points with weekly visits
- Sign up for the fitness program by calling **888.762.BLUE (2583)**

Blue365

With this program, you can save money on health care products and services that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations. Blue365 has a range of deals from top national and local retailers on dental, vision and hearing services, fitness gear, gym memberships, healthy eating options and much more.

Sign up on the Blue365 website at **blue365deals.com/BCBSIL** and start receiving weekly "Featured Deals." These deals offer savings from leading health companies and online retailers. Featured Deals are offered for a short period of time. In addition, below are some of the Blue365 deals available to you.

- ❑ **EyeMed Vision –** You can save on eyeglasses as well as contact lenses, exams and accessories. The EyeMed group is made up of national and regional retail stores as well as local eye doctors. Save on laser vision correction through LasikPlus.
- ❑ **Dental Solutions –** You can receive a dental discount card which provides access to discounts up to 50 percent at more than 61,000 dentists and more than 185,000 locations.*
- ❑ **Jenny Craig, Seattle Sutton's, Nutrisystem –** Save on healthy meals, membership fees (where apply), nutritional products and services.
- ❑ **Procter & Gamble (P&G) Dental Products –** You can get savings on dental packages with Oral B power toothbrushes and Crest products. Packages may include items such as an electric toothbrush, mouth rinse, teeth whiteners and floss.
- ❑ **TruHearing –** You can save an average of $890 per hearing aid compared to national retail prices. Each hearing aid comes with a 45-day money-back guarantee and a three-year warranty.
- ❑ **CORD:USE –** Protect your family's cord blood at a state-of-the-art laboratory using high-quality cord blood banking practices and technologies. Save on cord blood processing and storage fees.
- ❑ **Reebok –** You enjoy 20% off plus free shipping on their whole **Reebok.com** order.
- ❑ **SeniorLink Care –** You can find support to help your aging family members or friends lead fulfilling and comfy lives. From planning care to helping caregivers, SeniorLink helps seniors and loved ones find the programs and services they need most. You can save on a three- or 12-month membership.
- ❑ **BodyMedia –** You can enjoy up to 25% off a BodyMedia armband. The armband will track calories around the clock, helping members lose weight, stay active and lead healthier lives.
- ❑ **Life Time Fitness –** Life Time Fitness offers total health fitness to fit your level, interests, schedule and budget. For new members, Life Time Fitness offers a $0 online sign-up fee.

Flexible Spending Account (FSA) – Annual Election to Participate

A flexible spending program allows you to commit a certain monthly dollar amount to a savings account set aside for healthcare and dependent care expenses. Deciding how much money to set aside to fund your flexible spending account(s) can seem intimidating. A good rule of thumb is to thoroughly review your health care and dependent care expenses from the previous year to estimate how much you out-of-pocket money you spent (i.e. expenses not covered by insurance). The District 62 Flexible Spending Account program is offered through EBC Flex.

2025 FSA claims due no later than March 31, 2026, for 2025 expenses.

Healthcare FSA

A Healthcare FSA is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses.

Highlights of a Healthcare FSA:

- ❑ Individual/Family cap amount of $3,300 per plan year (January 1 - December 31)
- ❑ Save an average of 30% on a wide variety of eligible healthcare expenses by paying for them on a pre-tax basis
- ❑ Reimbursement types are dictated by Section 125 of the Internal Revenue Service and include items such as copays, deductibles, etc.
- ❑ No waiting - access the full amount of your annual election on the first day of the plan year
- ❑ Save time - use the EBC flexible spending debit card to pay for expenses at the point of sale (like you would with any other credit/debit card)
- ❑ Flexibility - Submit receipts for costs incurred that cannot be paid for at the point of sale and receive a reimbursement check in the mail.
- ❑ Any unused funds in the Healthcare FSA (beyond the $660 carryover) as of the last day of the plan year will be forfeited.
- ❑ For more information about the Healthcare FSA and/or a full list of eligible expenses, please visit: **www.ebcflex.com**.

Dependent Care Expenses

A Dependent Care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder care. Highlights of a Dependent Care FSA:

- ❑ Individual/Family cap amount of $5,000 per plan year (January 1 - December 31)
- ❑ Save an average of 30% on dependent care expenses by paying for them on a pre-tax basis
- ❑ Dependent care must be utilized for care services rendered during your normal work hours
- ❑ Start submitting claims for reimbursement as soon as money starts being deducted from your paycheck and accumulating in your account. Unlike the Healthcare FSA, money is only available after it has been deducted from your paycheck; you do NOT get the full amount of your annual election on the first day of the plan year.
- ❑ For more information about the Dependent Care FSA, please visit: **www.ebcflex.com**.

"Use it or Lose It"

Expenses eligible for reimbursement must be incurred by December 31, 2025 and filed for reimbursement before March 31, 2026 or the remaining balance will be forfeited.

The District will contribute to a Health Savings Account (HSA) to go along with your High Deductible Health Plan 1700 (HDHP) option. The District will contribute $800 for single coverage and $1,500 for family coverage. If more staff elect than the pool of money committed by the Board will cover, the amounts may be reduced. Family coverage is applicable to an employee who covers someone besides themselves on the health plan. This is a great opportunity for you to invest and group your healthcare dollars and take advantage of lower premiums.

What is a Health Savings Account (HSA)?

A Health Savings Account, most commonly called an HSA, is a bank account that you own and use to pay for now and future qualified health care expenses.

Key features include:

- ❑ The HSA is a tax-savings vehicle that lets you set aside tax-free money to pay for eligible health care expenses. You decide which expenses to pay from your HSA.
- ❑ Your balance rolls over year to year. HSA – There is no "use it or lose it" rule like in an FSA.
- ❑ If you leave your current employer or retire, you take the money with you; you own the account.

FAQs

Q. Who qualifies for an HSA?
A. You may open and contribute to an HSA if you meet all the below criteria:

- ❑ Enrolled in the HDHP
- ❑ Not covered by other medical insurance other than another HDHP
- ❑ Not claimed as a dependent on someone else's tax return
- ❑ Not enrolled in Medicare

Q. Does my employer have access to my HSA information?
A. No. Since you own and manage your own HSA, your employer cannot access or view your account.

Q. How much money can I contribute to my HSA each year?
A. In 2025, the maximum contribution for individual coverage is $4,300 and the maximum contribution for family coverage is $8,550. HSA account holders over the age of 55 can make an additional "catch up" contribution of $1,000 per year. These limits are set by the IRS and are typically increased each calendar year for a January 1st effective date.

Q. What happens to the money in my HSA if I change health plans, leave my current employer, or retire?
A. You own the HSA, so the money is yours to keep. If you retire and are insured by Medicare, or change to a non HSA-qualified plan you can still use the money in your HSA to pay for out-of-pocket qualified health care expenses but you won't be able to continue to make contributions to your HSA.

Q. Can I take the money out of my HSA any time I want?
A. Yes. You can take money out anytime, tax-free and without penalty, as long as it's used for qualified health care expenses. If you withdraw funds for other purposes, you will pay income taxes on the withdrawal plus a 20% penalty.

Q. Who owns the HSA?
A. You do.

Q. I enrolled in the HDHP but didn't elect to cover my dependents. Can I use my HSA to pay for my dependent's qualified health care expenses?
A. Yes. Your HSA can be used to pay for qualified health care expenses of any family member who qualifies as a dependent on your tax return. Remember, if the dependent isn't covered under your plan, his/her expenses won't apply toward your plan's deductible.

Q. My spouse has an FSA or HRA through their employer, can I have an HSA?
A. You cannot have an HSA if your spouse's FSA or HRA can pay for any of your medical expenses before your HDHP deductible is met.

Q. Can I use my HSA to pay for medical expenses incurred before I set up my account?
A. No. You cannot reimburse qualified health care expenses incurred before the date your account is established.

Q. If I incur an eligible expense but choose not to use money in my HSA to reimburse myself immediately, can I do so in the future?
A. Yes. Therefore, it is very important to keep your receipts for your health care expenses. You can withdraw funds from your HSA years after you incur the expense as long as you have the appropriate documentation.

Is the High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA) the right choice for you and your family?

While this is a great plan, it might not be the best choice for everyone based on specific lifestyles and life stages. To assist in your decision making process, below are a couple scenarios in which this plan could be the right choice.

Example 1: You are a young and healthy individual with single coverage
If you are young, healthy, and are not prone to accidents, the HDHP may be the best plan option for you. In 2025, you are allowed to contribute a single maximum of $4,300 minus the $800 the District contributes, tax-free, into the HSA. If you do not experience many medical expenses, the remaining dollars will roll over to the next year and will continue to grow tax-free.

Example 2: You are close to retirement and are relatively healthy
If you are on a family plan and are over age 55, the maximum amount that you and the District can contribute to the HSA is $8,550 (over 55 can contribute an extra $1,000), your unused dollars will accumulate and can be used to pay your Medicare premiums and healthcare expenses after your retire.

Example 3: You or a family member has a medical condition with money already saved in an HSA
An employee who has been contributing the family maximum into their HSA account for the last two years would have built up a bank of $14,500 over a two year period. If your family spends an average of $1,500 a year on medical expenses (doctors visits, prescription medication, etc.) the amount in your account after two years equals $14,500-$3,000= $11,500. If someone in your family has a chronic illness beginning in the third year, you would have enough money to reach the $7,150 out-of-pocket limit for the year.

Optional Coverages Available: Dental

CCSD 62 recognizes that different individuals have varying comfort levels and needs in regards to insurance. It is important that you analyze a variety of factors to determine where you and your family need expanded coverage (e.g., risk factors, age, wellness, and medical history).

Semi-annual dental checkups are important, no matter your age. Dependent dental eligibility now covered to age 26, unless they are eligible for other employer-provided coverage.

MetLife Dental PPO Plan – Offers the luxury and convenience of choice. You choose which dental professionals you and your family see.

A dental ID card is not necessary to receive services or benefits; however, you can request a MetLife book with cards if needed from your HR Benefit area. Just be sure to bring a MetLife Dental Claim Form (which you can get by printing from the website or by calling the Employee Benefit Line) with you to your first appointment, and your dentist will take care of the rest!

MetLife offers you both telephonic and web access to your personal information to assist you in managing your dental benefits.

Telephonic: You can contact the Employee Benefits Line at **800.942.0854**. This line is available weekdays from 8 a.m. to 8 p.m., and you can verify eligibility status, review plan benefits, check on the status of a claim, get claim forms, and order a customized directory.

Web: You can access MyBenefits at **www.metlife.com/mybenefits**. This website offers you the ability to manage your personal information on your own personalized homepage, where you can view claims status and eligibility information, as well as view a summary of your dental benefits.

If you have claim issues that you have not been able to successfully resolve on your own, you may contact your District Business Office.

Dental PPO Plan Benefits		
Benefit	**Network**	**Non-Network**
Annual Benefit	$1,500	$1,500
Annual Deductible (3x Family) Per Person	$25	$25
Diagnostic	100%	100%
Preventive (cleanings and exams)	100%	100%
Basic Services (basic perio, crowns, inlays, onlays)	80%	80%
Major Restorative (major perio, crowns, inlays, onlays)	60%	60%
Orthodontics*	50%	50%
Orthodontics Lifetime Limit (children to age 19)	$2,000	$2,000

VISION BENEFITS

Vision Benefits

Our health plan offers multiple ways to save on vision services. Employees covered through the Blue Cross Medical plan have access to both Blue Cross's EyeMed Vision Discount program and a vision allowance plan. Employees who do not participate in our medical plan can join our VSP vision program. Please read on for further details.

Vision Allowance Program for PPO 500 and PPO 750 Members

In addition to the EyeMed Vision discount program, our medical policy through Blue Cross provides a $30 allowance towards an annual vision exam for you and your covered family members as well as a $200 allowance for materials every 12 months. In order to obtain your reimbursement you need to submit your vision expense to Blue Cross along with a medical claim form. Medical claim forms can be obtained through Blue Cross's website.

Vision Allowance Program for HMO Members

Employees and covered dependents enrolled in the District's HMO plan are entitled to an annual eye exam at no additional cost. In addition, you are entitled to $150 towards contact lenses and $225 towards frames every 24 months. **Please note, you must use a EyeMed Vision Care provider to receive benefits. To locate a provider, call EyeMed Vision Care at 844.684.2254.**

Vision Discount Programs

As a member of BCBS, you are eligible to participate in a vision discount program that offers discounts on eye exams, contact lenses, frames, lenses and lens add-ons. In order to receive this vision discount, you will need to present your BCBS medical ID card at the time of service.

PPO, HDHP and HMO members: The vision discount program is administered by EyeMed Vision Care. EyeMed Vision Care contracts with national providers, including LensCrafters, Pearle Vision, Sears Optical, Target Optical and JCPenney Optical and other independent providers. To locate a provider, call EyeMed Vision Care at **844.684.2254**.

VSP Program

The VSP vision program allows employees and retirees who DO NOT take medical coverage through the District to participate in a voluntary vision program. If you are participating in this plan you can locate a participating provider on the web at **www.vsp.com** or by calling VSP at **800.877.7195**. When you make the appointment with a participating provider, identify yourself as a VSP member, your doctor and VSP will handle your claims. You will pay your portion of any expenses at the time of purchase at the participating provider's office. You can also choose a non-participating provider. When you use a non-participating provider you will need to pay the provider in full at the time of service and submit a claim form to VSP directly for reimbursement. VSP asks that you contact them at **800.877.7195** before seeing a non-network provider. The VSP benefits are as follows:

Services	VSP Network	Open Access Provider Allowance
Exams, annually	$20 copay	Maximum of $50
Single Vision	In full, every 24 months	Maximum of $50, once every 24 months
Lined Bifocal	In full, every 24 months	Maximum of $75, once every 24 months
Lined Trifocal	In full, every 24 months	Maximum of $100, once every 24 months
Frame	Up to $130 in full, every 24 months, Plus 20% discount	Maximum of $70, once every 24 months
Contacts, once every 24 months*	Visually necessary in full, elective professional fees and materials up to $130 allowance	Visually necessary up to $210, elective professional fees and materials up to $105 allowance

*In lieu of all other lens and frames.

SUPPLEMENTAL LIFE AND AD&D

Supplemental Life and AD&D Insurance

Employees may elect to purchase additional Life and AD&D insurance in $10,000 increments up to a maximum of the lesser of 5 times your annual salary or $500,000. Newly eligible employees have a guaranteed issue amount up to $150,000, no medical questions required. If electing over the stated guarantee issue amounts, or when electing coverage when not first eligible, you will be required to complete evidence of insurability (medical questions).

Spouse insurance can be purchased at the same amount as the employee, not to exceed 50% of the employee's coverage amount. Newly eligible spouses are guaranteed up to $25,000 in coverage. If electing over the guarantee issue amount, or when electing coverage when not first eligible, you will be required to complete evidence of insurability (medical questions).

Employees can also purchase up to $10,000 in optional child life insurance coverage. Dependent children life coverage is guarantee issue.

Monthly Premium Rates

Employee Age	Rate per $1,000 per month
Less than 25	$0.68
25-29	$0.70
30-34	$0.78
35-39	$0.109
40-44	$0.151
45-49	$0.224
50-54	$0.359
55-59	$0.658
60-64	$1.278
65-69	$2.098
70 and over	$3.879
Personal AD&D	$0.019

Spouse Age	Rate per $1,000 per month
Under 25	$0.68
25-29	$0.70
30-34	$0.78
35-39	$0.109
40-44	$0.151
45-49	$0.224
50-54	$0.359
55-59	$0.658
60-64	$1.278
65-69	$2.098
70 and over	$3.879
Spouse AD&D	$0.019

Dependent Child	Rate per month
Per $1,000 in Life coverage	$0.131
Per $1,000 in AD&D Coverage	$0.053

NOTE: The cost is not per child but for all eligible dependent children

Employee Assistance Program

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 800.272.7255
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: COM589

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

Contact Your GuidanceResources® Program

Call: 800.272.7255
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: COM589

COMMUTER BENEFITS

CCSD 62

Commuter Benefits

Employee Benefits Corporation

Commuter Benefits

Save money on eligible commuter expenses.

Commuter Benefits offer tax savings on work-related commuting expenses. When you contribute to a commuter account, you save approximately 30%* on eligible expenses, making a $100 eligible purchase cost you about $70. You get these savings because the contributions you make to your commuter account are exempt from Federal, State, and FICA payroll taxes.

*This tax example is a broad approximation of tax liability. Your specific savings depend on your tax bracket. Further, your contributions may be subject to state income tax in some states. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all pre-tax payment and contribution matters and are subject to change.

Commuter Options

The following account(s) are available to you:

Transit
Transit accounts can be used to pay for eligible transit expenses to and from your primary workplace. Eligible transit expenses are defined as passes, tokens, fare cards, vouchers, or similar for:

- Mass transit (such as the train, bus, subway, or ferry)
- Commuter highway vehicles (such as vanpool)

Next Steps

1. View Eligible Expenses
Consider which eligible expenses you can use your commuter funds on to help inform your contribution amount. These expenses will vary depending on which account type you enroll in. For more information on eligible commuter expenses, visit www.ebcflex.com/eligibleexpenses .

2. Choose Your Contribution Amount
After considering the eligible expenses, decide how much you would like to contribute to your commuter account. You can elect to contribute up to the established limit:

Transit Account | **$315 per month** Parking Account | **$315 per month**

3. Manage Your Contributions
Commuter contributions are done on a monthly basis , so you must make your election by the 13th of the month prior to receiving the benefit. You can set up recurring contributions of the same amount or change it each month.

4. Use Your Commuter Funds
Use your Benefits Card to pay for commuter expenses directly from your account. Simply swipe the card, use it to pay online, set up the card in the app you use to pay for eligible commuter expenses, or primary cardholders can add it to their digital wallet to use when contactless payments are required.

Contact Us www.ebcflex.com (800) 346-2126 participantservices@ebcflex.com |

YOUR NEXT STEPS

Carefully Review Your Enrollment Options

- ❑ Open enrollment dates are October 18, 2024 through October 28, 2024.
- ❑ If you are currently enrolling new dependents, proof documents are required to be submitted with your enrollment including social security numbers.
- ❑ Complete and submit your online enrollment by the end of day on October 30, 2024.

Important Contact Information

If you would like to further research your benefit options, find a provider, or ask detailed questions about your benefit coverage, you may contact the insurance companies/service provider directly. Listed below are toll-free phone numbers and websites for those that provide services for CCSD 62 employees.

Benefit	Administrator	Phone	Website / Email
Medical PPO and HDHP	BCBS	800.458.6024	www.bcbsil.com
Medical HMO	BCBS	800.892.2803	www.bcbsil.com
Dental PPO/Basic and Supplemental Life and AD&D	MetLife	800.942.0854	www.metlife.com/mybenefits
Vision	VSP EyeMed	800.877.7195 844.684.2254	www.vsp.com www.eyemedvisioncare.com/bcbsil
Flexible Spending Account (FSA)	EBC Flex	800.346.2126	www.ebcflex.com
Health Savings Account (HSA)	BenefitWallet	877.472.4200	www.mybenefitwallet.com
Employee Assistance Program (EAP)	ComPsych	312.595.4000	www.compsych.com
Commuter Benefits	Employee Benefits Corporation	800.346.2126	www.ebcflex.com

If you have questions regarding the enrollment process, your payroll deductions, or need general benefit information, please contact Julie Salmons Hubbard via phone **847.824.1185**, or by email, **salmonshubbardj@d62.org**.

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, 2024. 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.mycohibi.com/ 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
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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 | KIHIPPPROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 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/health-care-coverage/ 800.657.3672
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. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
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 and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 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 and CHIP
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, 2024, or for more information on special enrollment rights, contact either:

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

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 states 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 physician 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.

If you would like more information on WHCRA benefits, call Blue Cross Blue Shield of Illinois.

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).

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct your health information if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20211, calling **877.696.6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.

Address workers compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

HIPAA Special Enrollment Rights

Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the District's Health Plan (to actually participate, you must complete an enrollment form and 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 30 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 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 your plan administrator.

Discrimination is Against the Law

Des Plaines CCSD 62 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Des Plaines CCSD 62 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Des Plaines CCSD 62

Will guide you to free aids and services to people with disabilities to communicate effectively with us, such as:

- ❑ Qualified sign language interpreters
- ❑ Written information in other formats (large print, audio, accessible electronic formats, other formats)

Will guide you to free language services to people whose primary language is not English, such as:

- ❑ Qualified interpreters
- ❑ Information written in other languages

If you need assistance with these services, contact Human Resources.

If you believe that Des Plaines CCSD 62 has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Human Resources, 777 E. Algonquin Rd, Des Plaines, IL 60077.** You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Human Resources, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20211
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Translated Resources

Under Section 1557 of the Affordable Care Act (ACA), covered entities are required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services. The translated resources below are the top 15 languages used in Illinois and are available for use by the District.

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877.696.6775.

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877.696.6775.

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 877.696.6775.

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877.696.6775 번으로 전화해 주십시오.

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877.696.6775.

(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن الخدمات المساعدة اللغوية تتوافر لك بالمجان برقم اتصل 1-877.696.6775.

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877.696.6775.

(Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 877.696.6775.

(Urdu)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 877.696.6775.

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877.696.6775.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877.696.6775.

(Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 877.696.6775. पर कॉल करें।

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 877.696.6775.

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 877.696.6775.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877.696.6775.

Allowed Amount. Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing. When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider should not balance bill you.

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

Brand Name Drug: 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%.

Copayment. 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.

Deductible Carry-Over. In some benefit plans, not Health Savings Account Compatible Plans, if you have not met your annual deductible during the last three months of the plan year the claims incurred may apply toward the deductible for the next plan year.

Emergency Medical Condition. An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

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 Drug: A list of prescribed medications that are preferred by your plan because they are safe, effective alternatives 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 health care providers and health plans to protect patient records.

Hospitalization. Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

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. 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.

Plan. A benefit your employer, or other group sponsor provides to you to pay for your healthcare services.

Plan Year. The period of time in which plan coverage and records are based. For the District's plan, it is the calendar year. (For example, the annual deductible, annual out-of-pocket maximum, and maximum annual benefit all apply to expenses incurred during the plan year.)

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.

Premium. The amount you pay for your health care coverage and other benefits, through payroll deductions.

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 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.

Urgent Care. Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Voluntary Benefits. Optional benefit plans sponsored by the employer, but fully paid for by employees who elect coverage. These benefits are generally available at special group rates or discounts, making them more cost-effective than employees could obtain on their own.

Waiver of Premium. Rider or provision included in the life insurance policy exempting the insured from paying premiums after insured has been disabled for a specified period of time.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Employer Name:	Community Consolidated School District 62
Employer State of Situs:	Illinois
Name of Issuer:	BlueCross/BlueShield of Illinois
Plan Marketing Name:	BCO 500, BCO 750, and HDHP 1700
Plan Year:	2025

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

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

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Employer Name:	Community Consolidated School District 62
Employer State of Situs:	Illinois
Name of Issuer:	BlueCross/BlueShield of Illinois
Plan Marketing Name:	HMO Illinois and Blue Advantage HMO
Plan Year:	2025

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8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

DES PLAINES SCHOOL DISTRICT 62
WORKING TOGETHER FOR OUR CHILDREN

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting