2027 Benefits



Oak Lawn Community High School District 229

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This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.



Getting Started

2027 Benefits

At Oak Lawn Community High School District #229 we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices section for more details.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

Who's eligible for benefits?



Employees

You are eligible if you are a full-time employee working 30 or more hours per week.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Employees become eligible to transition to the PPO insurance plan after completing three years of full-time service in District 229 and may enroll during the open enrollment period in their fourth year of employment.

Eligible dependents

- Legally married spouse
- Biological, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of Oak Lawn Community HS Dist. 229 cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

*You must provide documentation of dependent eligibility. For a spouse, provide a copy of your marriage or civil union certificate. For children, provide a copy of birth certificates, adoption or legal custody documents, etc.

For additional coverage information, please refer to the benefit booklets for each benefit.

When you can enroll

Coverage for new employees begins on the first day of the month following employment. Existing employees can enroll during the annual open enrollment period.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment.

Changing your benefits

Click to play video



Life happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit any changes within 30 days after the event.

Employee assistance program (EAP)



Contact the EAP

Phone: (800) 456-6327

https://perspectives.mylifeexpert.com/

Username: Oak503

Password: perspectives

Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through AllOne Health can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues. Unlimited web access to helpful articles, resources, and self-assessment tools.

Counseling

- Relationship challenges
- Emotional distress
- Job stress
- Communication issues
- Interpersonal conflict
- Alcohol or drug use
- Loss and grief

Elder care

- Help finding care resources for elderly or disabled relatives

Legal

- Local attorney referrals
- Family law (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Parenting & childcare

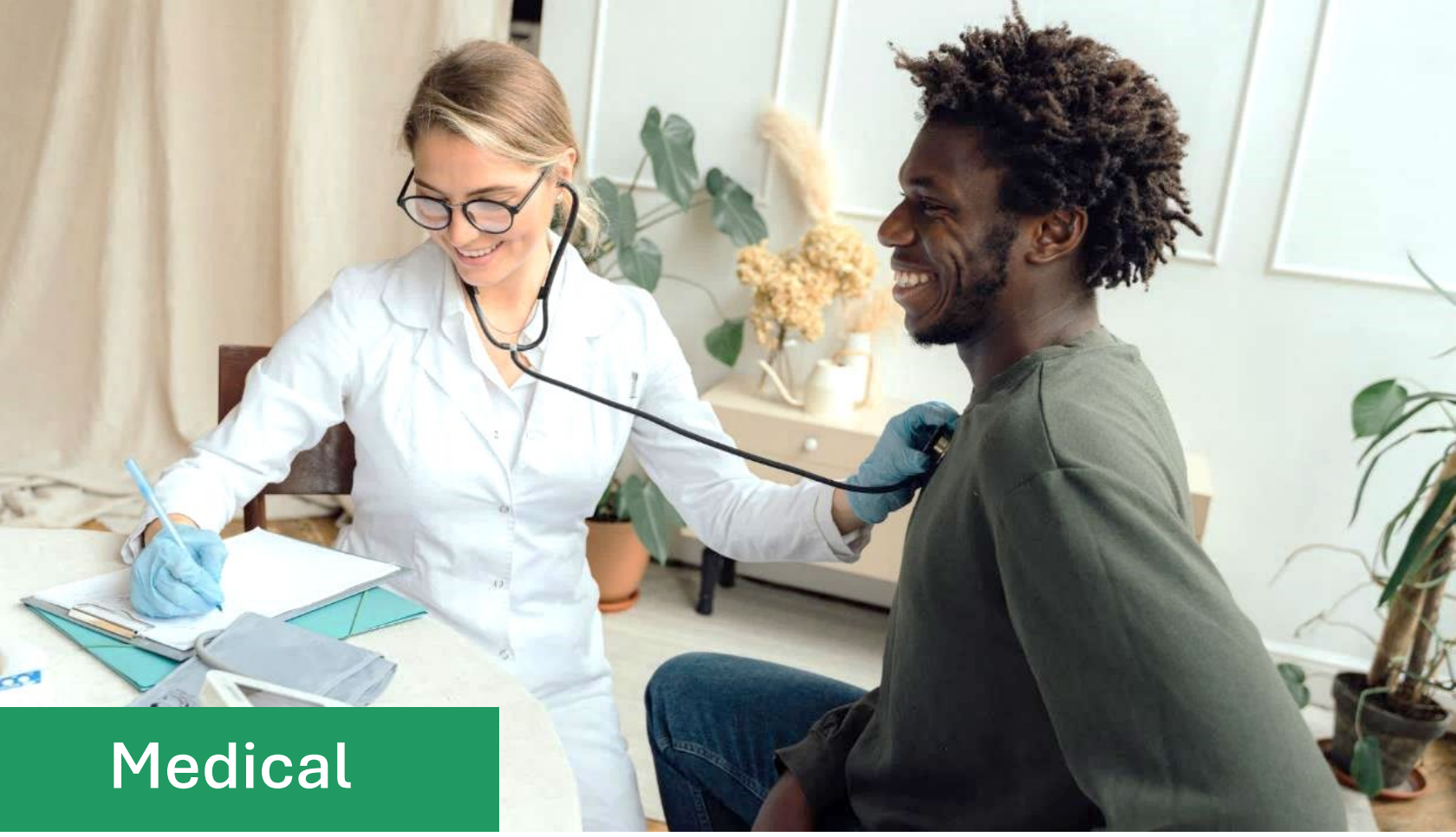
- Quality referrals
- Family day care centers
- Infant centers and preschools
- Before- and after-school care
- 24-hour care

Financial

- Money/debt management
- Identity theft resolution
- Tax issues

Online resources

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics



Medical

Words To Know

Learn the words that will help you understand how your plan works.

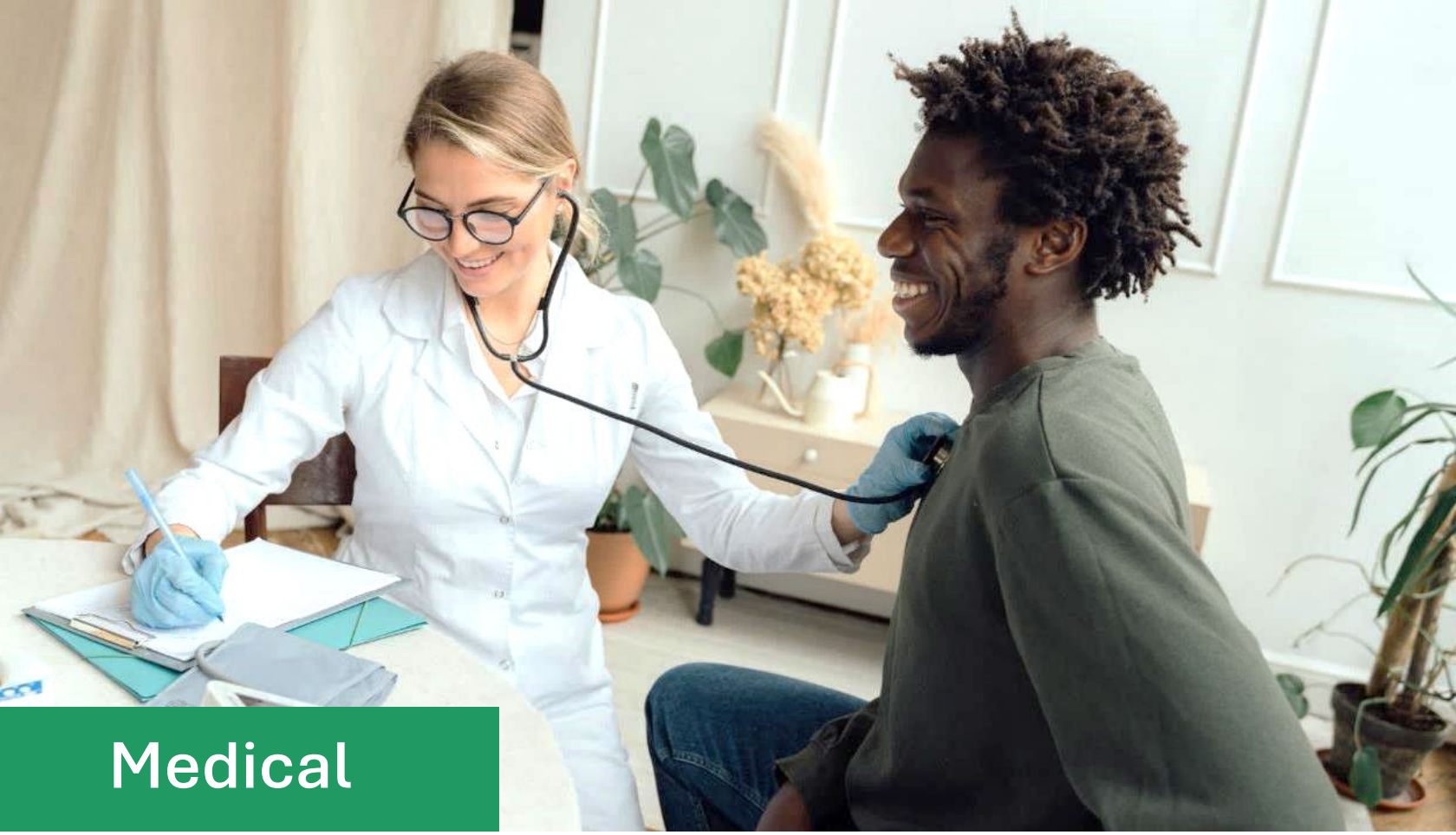
Deductible: The total healthcare costs you pay for with your own money before your plan will start to pay a portion.

Out-of-pocket maximum: Once you've spent this amount on covered medical services, your insurance pays 100% of most eligible expenses for the rest of the plan year.

Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your share of the cost (your coinsurance) is 20%. You are billed for your coinsurance after your visit.

Copay: A set fee (rather than coinsurance) for certain healthcare services—for example, a doctor's office visit. You pay the copay at the time you receive care.

In-network/out-of-network: In-network services will always be the lowest-cost option. Out-of-network services will cost more or may not even be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.



Medical

Our Plans

BCBSIL BlueAdvantage HMO Plan

BCBSIL BlueChoice Options PPO Plan

BCBIL BlueChoice Options HSA Plan

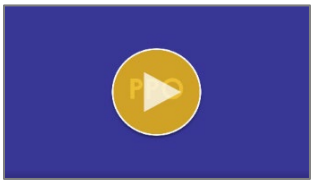
BlueCross BlueShield of Illinois

HMO, PPO, HDHP—what's the difference?

Not all medical plans work the same. These videos will help you understand how each type of plan works *(click images to play videos)*.



HMO

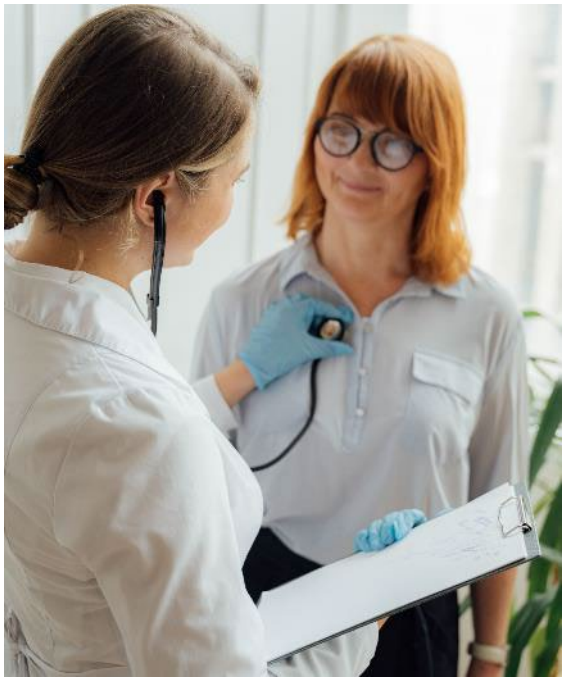


PPO



HSA

Which plan is right for you?



Plan type definitions

- **HMO:** health maintenance organization
- **PPO:** preferred provider organization
- **HDHP:** high deductible health plan

Consider an HMO if:

- You want lower, predictable out-of-pocket costs.
- You like having one doctor to manage your care.
- You are happy with the selection of network providers.
- You don't see any doctors that are out-of-network.

Plan to consider

- BlueAdvantage HMO Plan

Consider a PPO if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).

Plan to consider

- BlueChoice Options PPO Plan

Consider an HDHP if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).
- You want tax-free savings on your healthcare costs.
- You want to build a savings account for future healthcare costs for you and your eligible family members.
- You want an extra way to add to your retirement savings.

Plan to consider

- BlueChoice Options HSA Plan

Medical BlueAdvantage HMO

The HMO plan requires that you select a medical group and primary care physician (PCP) from the Blue Advantage HMO Advantage network. All care must be coordinated by your PCP or medical group, including any referrals. Benefits are in-network only; there is no benefit outside of the Blue Advantage HMO network.

Benefit	In-Network Only (requires PCP selection)
Deductible	None
Out-of-pocket maximum	**Individual:** $1,500 **Family:** $3,000
Office visit	**PCP:** $20 copay **Specialist:** $20 copay (referral required)
Preventive Services	Plan pays 100%
Lab and X-ray	Plan pays 100%
Urgent care	$20 copay (referral required)
Emergency room	$100 copay (waived if admitted)
Hospitalization	Plan pays 100% (referral required)
Outpatient surgery	Plan pays 100% (referral required)
Prescription drugs	
Annual out-of-pocket maximum	**Individual:** $1,000 **Family:** $2,000
Generic	**Retail:** $10 copay **Mail:** $20 copay
Preferred Brand	**Retail:** $20 copay **Mail:** $40 copay
Non-Preferred Brand	**Retail:** $35 copay **Mail:** $70 copay
Specialty	**Retail:** $35 copay **Mail:** N/A
Number of days' supply	**Retail:** 34 days **Mail:** 90 days

Medical BlueChoice Options PPO

BlueCross BlueShield of Illinois

A PPO plan allows you to receive care in-network or out-of-network. You always pay the deductible and copays, up to the out-of-pocket maximum. Coinsurance is what the plan pays after the deductible is met.

The plan is a "BlueChoice Options" plan because it gives you access to 3 network tiers:

$ Tier 1: BlueChoice Options (BCO): You pay the least out-of-pocket amount
$$ Tier 2: PPO: You pay a higher out-of-pocket than BCO, but still considered in-network
$$$ Tier 3: Out-of-Network: You pay the highest out-of-pocket cost and may be subject to balance-billing.

Amounts applied to deductible and out-of-pocket cross accumulate between the Tier 1 BCO and Tier 2 PPO network. Credit is applied to both.

Benefit	BCO Network(Tier1)	PPO Network(Tier 2)	Out of Network(Tier 3)
Deductible	**Individual:** $400 **Family:** $800	**Individual:** $800 **Family:** $1,600	**Individual:** $1,600 **Family:** $3,200
Out-of-pocket maximum	**Individual:** $1,400 **Family:** $3,800	**Individual:** $2,800 **Family:** $7,600	**Individual:** $5,600 **Family:** $15,200
Office visit	**PCP:** $20 **Specialist:** $40	**PCP:** $25 **Specialist:** $50	**PCP:** Plan pays 60% after deductible **Specialist:** Plan pays 60% after deductible
Preventive Services	No Charge	No Charge	Plan pays 60% after deductible
Lab and X-ray	Plan pays 80% after deductible	Plan pays 70% after deductible	Plan pays 60% after deductible
Urgent care	Plan pays 80% after deductible	Plan pays 70% after deductible	Plan pays 60% after deductible
Emergency room	$150	$150	$150
Hospitalization	Plan pays 80% after deductible	Plan pays 70% after deductible	Plan pays 60% after deductible
Outpatient surgery	Plan pays 80% after deductible	Plan pays 70% after deductible	Plan pays 60% after deductible
Prescription drugs	**BCO Network**	**PPO Network**	**Out of Network**
Annual out-of-pocket maximum	**Individual:** $1,000 **Family:** $2,000	**Individual:** $1,000 **Family:** $2,000	**Individual:** $1,000 **Family:** $2,000
Generic	**Retail:** $10/prescription **Mail:** $20/prescription	**Retail:** $10/prescription **Mail:** $20/prescription	**Retail:** $10/prescription **Mail:** N/A
Preferred Brand	**Retail:** $40/prescription **Mail:** $80/prescription	**Retail:** $40/prescription **Mail:** $80/prescription	**Retail:** $40/prescription **Mail:** N/A
Non-Preferred Brand	**Retail:** $60/prescription **Mail:** $120/prescription	**Retail:** $60/prescription **Mail:** $120/prescription	**Retail:** $60/prescription **Mail:** N/A
Specialty	**Retail:** $60/prescription **Mail:** N/A	**Retail:** $60/prescription **Mail:** N/A	**Retail:** $60/prescription **Mail:** N/A
Number of days' supply	**Retail:** 34 days **Mail:** 90 days **Specialty:** 30 days	**Retail:** 34 days **Mail:** 90 days **Specialty:** 30 days	**Retail:** 34 days **Mail:** N/A **Specialty:** 30 days

Medical BlueChoice Options HSA

BlueCross BlueShield of Illinois

The below HSA plan is a High Deductible Health Plan (HDHP) combining a PPO plan with a Health Savings Account (HSA), funded by pre-tax dollars by you. The plan pays after the deductible is met.

The plan is a "BlueChoice Options" plan because it gives you access to 3 network tiers:

$ Tier 1: BlueChoice Options (BCO): You pay the least out-of-pocket amount
$$ Tier 2: PPO: You pay a higher out-of-pocket than BCO, but still considered in-network
$$$ Tier 3: Out-of-Network: You pay the highest out-of-pocket cost and may be subject to balance-billing.

Amounts applied to deductible and out-of-pocket cross accumulate between the Tier 1 BCO and Tier 2 PPO network. Credit is applied to both.

Benefit	BCO Network	PPO Network	Out of Network
Deductible	**Individual:** $3,400 **Family:** $6,800	**Individual:** $4,000 **Family:** $8,000	**Individual:** $6,000 **Family:** $12,000
Out-of-pocket maximum (Embedded)	**Individual:** $3,400 **Family:** $6,800	**Individual:** $5,000 **Family:** $10,000	**Individual:** $10,400 **Family:** $20,800
Office visit	**PCP:** Plan pays 100% after deductible **Specialist:** Plan pays 100% after deductible	**PCP:** Plan pays 80% after deductible **Specialist:** Plan pays 80% after deductible	**PCP:** Plan pays 60% after deductible **Specialist:** Plan pays 60% after deductible
Preventive Services	No Charge	No Charge	Plan pays 60% after deductible
Lab and X-ray	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent care	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency room	Plan pays 100% after deductible		
Hospitalization	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient surgery	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Prescription drugs	**BCO Network**	**PPO Network**	**Out of Network**
Generic	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible
Preferred Brand	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible
Non-Preferred Brand	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible
Specialty	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible	**Retail:** Plan pays 100% after deductible
Number of days' supply	**Retail:** 34 days **Mail:** 90 days **Specialty:** 30 days	**Retail:** 34 days **Mail:** 90 days **Specialty:** 30 days	**Retail:** 34 days **Mail:** N/A **Specialty:** 30 days

Provider Search-BCO Plans

BlueCross BlueShield of Illinois

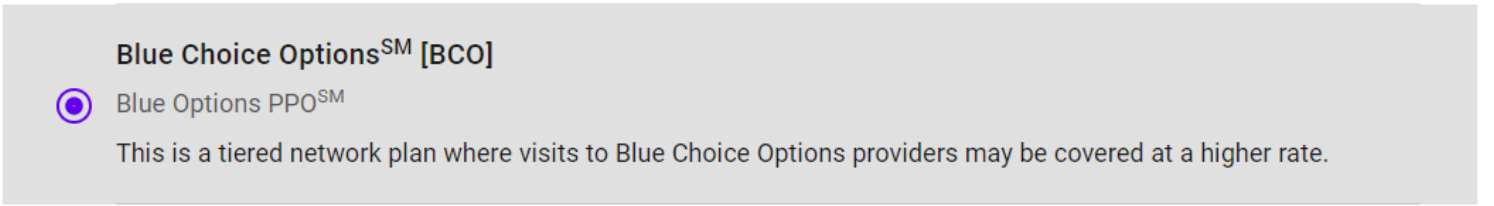
Medical Plan

1. Go to www.bcbsil.com.

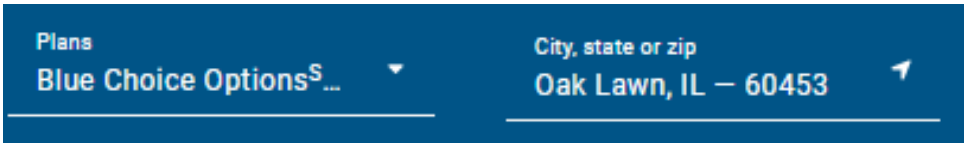
2. Near the top of the screen in the blue bar, click on the box labeled “Find Care”. From here a drop-down box will appear and you can click “Find a Doctor or Hospital”. You can then scroll down to **search as a guest**.

3. For Doctor/Hospital search, you will enter the city, state or zip code you wish to search in. Next, select “Employer Plans” and enter your state. Then click on “PPO”.

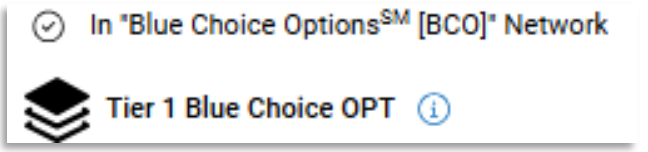
4. The type of PPO plan you will select is “Blue Choice Options [BCO]” from the list of options:



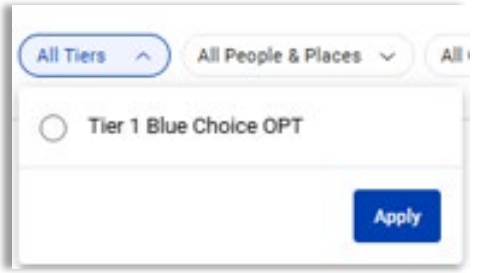
You can search for specific providers or do a general search for medical care.

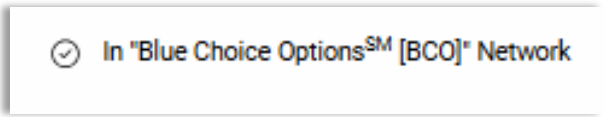


The search options will automatically show results for only ***Tier 1 Blue Choice OPT*** providers:



If you still want to search for additional providers in the Tier 2 PPO network, under the filter choices, click “Tiers” and click “clear” then “Apply”. A Tier 2 network provider will not include a “Tier 1” indicator.





You can sort by Tier, distance, alphabetically, quality and best match.

Preventive care



Typical screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

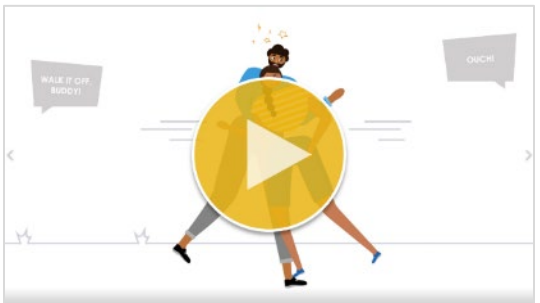
If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Know where to go

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for ...
Nurse line ($) Often available 24/7 at no cost	• quick answers from a trained nurse: – to determine if immediate care is needed – for home treatment options & advice
Online visit ($) Often available 24/7	• non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit ($$) Typically open during regular business hours	• routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care ($$$) Typically open with extended evening and weekend hours	• urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room ($$$) Open 24/7	• life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

BCBSIL member resources

BlueCross BlueShield of Illinois

New to your health plan? Use this checklist to get started:

1. Activate your member account

Just like on any website, when you sign into your health plan account, you'll find easier ways to view your personalized information and manage the details of your plan. Here are a few things you can do when you set up your account and use your member site, BlueAccess for Members:

- Find network doctors and pharmacies
- Find and estimate costs
- View and pay claims
- Check your account balances
- Learn about covered preventive care

Sign in to bcbsil.com

2. Download the BCBSIL app

The BCBSIL app makes it easier to check your plan details and view your member ID card from your mobile device. Depending on your plan, you may be able to use the app to take care of tasks like:

- Find nearby care options in your network
- Video chat with a doctor 24/7
- Check your progress toward your deductible

3. Stay in the network

The doctors and facilities in our network have agreed to provide services at a discount — so staying in network makes sense, especially when visiting an out-of-network provider could cost you a lot more for care. Find network doctors, mental health professionals, pharmacies, hospitals, labs and more by signing into your health plan member account.

4. Explore your pharmacy benefits

To get familiar with your **prescription drug coverage**, it's best to sign in to your health plan account.

After you get signed in, go to pharmacy and prescription coverage to:

- See your medication cost and coverage
- Locate a network pharmacy
- See if your medications have any requirements like prior authorization or step therapy, before filling them

THINGS TO KNOW

When to use the ER: The emergency room shouldn't be your first choice unless there's a true emergency – a serious or life-threatening condition that requires immediate attention or treatment that is only available at a hospital.

When to use Urgent Care: Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu and fever up to 104°. Find a network urgent care center at www.bcbsil.com.
HDHP/HSA plan members can also call the 24/7 Nurseline to connect with an experienced nurse at the number listed on their ID card. *HMO plan members should ask their designated medical group if they offer a similar hotline.*

Virtual Visits: HDHP/HSA plan members can video chat with a doctor from the convenience of their own homes, without an appointment. MDLive provides access to U.S. board-certified physicians, sometimes at a fraction of the cost of an office visit. Physicians treat a host of common illnesses quickly through real-time video visit. They can even send prescription orders to your local pharmacy. Sign in to BlueAccess for Members. *HMO plan members should ask their designated medical group if they offer virtual visits.*

Get the most from BCBSIL



Mail Order Prescriptions

Save time and money by getting eligible prescriptions, such as maintenance medications, through mail order. Express Scripts administers the mail order program.

Blue365 Discounts

As a BCBSIL member, you have access to wide range of health and well-being deals for national and local providers. Save money on gym memberships, vision exams and services, hearing aids, diet-related services, and more. Many of the discounts even extend to family members! Register at www.blue365deals.com/bcbsil and weekly "Featured Deals" will be emailed to you.

Well onTarget

The Well onTarget member wellness portal provides you with tools to help you set and reach your wellness goals. Visit www.wellontarget.com to register. Take a Health Assessment, track your health, and access self-directed courses and materials. Not only does the program help you meet your wellness goals, but you earn Blue Points that are redeemable for gift cards. Sync your fitness tracker with Well onTarget for easy integration and get rewarded for activities you're already doing!

Fitness Program

Available exclusively to members and their covered dependents age 18+, the Fitness Program provides access to a nationwide network of thousands of participating fitness locations. Membership is flexible and affordable – no long-term contract is required. Search for participating fitness centers online near your home, work, and when traveling in the U.S. You are also rewarded Blue Points for joining the program and regular visits each week. Just login to Blue Access for Members and click "Fitness Program" under the Wellness section to get started!

Women's and Family Health

This program is not available to HMO members.

Whether you are pregnant or planning to get pregnant, BCBSIL has tools to help you prepare, at no cost to you. The Ovia Health™ apps will track your cycle, pregnancy and baby's growth, and provide videos, tips, coaching and more. Plus, if your pregnancy is high-risk, BCBSIL will provide support from maternity specialists to help you care for yourself and your baby. Download any of the Ovia Health apps to your phone. During sign-up, choose "I have Ovia Health as a benefit." Then select BCBSIL as your health plan and enter your employer name. Call (888) 421-7781 to learn more.

Get the most from BCBSIL



Learn to Live

This program is not available to HMO members.

Digital mental health programs through Learn to Live can help you get your mental health on track so you can feel better and enjoy life more. Take an online assessment to help pinpoint the right programs for you, such as stress, anxiety, worry, depression, insomnia, social anxiety, and substance abuse. You can explore quick and easy lessons whenever it fits your schedule. If you need one-on-one support to reach your goals, connect with a coach by phone text or email. All information is completely confidential and will not be shared with your employer. Login at www.bcbsil.com, Click Wellness, then choose Digital Mental Health.

Wondr Health

Wondr Health™ is an online mindful eating behavior modification program proven to deliver sustainable weight loss and reverse obesity, pre-diabetes, and cardiovascular disease. When you enroll in the program, you'll receive a Welcome Kit and then you can access weekly video lessons and mindful eating tools.
Learn more or apply at www.wondrhealth.com/BCBSIL.

MyBlueRxIL Digital App

The MyBlueRxIL mobile app removes confusion and complexity from the pharmacy experience. With the MyBlueRxIL app, members can compare drug costs at different pharmacies, receive refill reminders, search for in-network pharmacies, see drug costs and lower cost options, view claims and prior authorization status, and learn about their prescriptions such as side effects, dosing instructions and drug interactions.
Download the free app and use your Blue Access for Members login credentials.

24/7 Nurseline

This program is not available to HMO members.

HDHP/HSA members have access to BCBSIL's 24/7 Nurseline. Speak with a registered nurse at any time of day to help decide whether you should go to the ER, urgent care center, or make an appointment with your doctor. Common cases include allergies, asthma, dizziness, high fever, 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, with more than 500 topics available in Spanish. Call the number on the back of your ID card.

Prescription drug information

Coverage for prescription drugs are included in the BCBSIL medical plans. Prime Therapeutics is the Pharmacy Benefits Manager.

Click to play video



The formulary drug tiers determine your cost

$	Generic drugs
$$	Brand-name drugs
$$$	Specialty drugs

Prescriptions breaking your budget?

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

Health savings account (HSA)

Click to play videos





Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the BlueChoice Options HSA plan
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not a tax dependent.
- Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today, and save for expenses you may have in the future. AmeriFlex administers this account.

How the HSA plan works

- To help you get started, Oak Lawn Community High School District 229 makes a contribution to your HSA:

  Individual: $500
  Family: $1,000

- You can contribute up to the limit set by the IRS (includes Oak Lawn Community High School District 229 contribution).

  Individual: $4,500 per year
  Family: $9,000 per year
  Age 55+: $1,000 extra per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Healthcare flexible spending account (FSA)

Click to play video



Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan like our BCO HSA, you can only participate in the Limited Purpose FSA for dental and vision expenses.

Find out more

- https://myameriflex.com/
- Eligible Expenses
- Ineligible Expenses

Do you pay for day care?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the FSA works

- You estimate what your and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- You can contribute up to $3,500, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $700 to use the following year. Any additional remaining balance will be forfeited.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables, but here's an example using single-filer status and marginal federal income tax rates:

$60,000 annual pay, contributing $1,500 to FSA

$330	$115	$445
22% income tax savings	7.65% FICA tax savings	Total FSA tax savings

$120,000 annual pay, contributing $3,200 to FSA

$768	$244	$1,012
24% income tax savings	7.65% FICA tax savings	Total FSA tax savings

Paying for daycare? Make it tax-free!

Click to play video



Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $7,500 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Ameriflex.

Here's how the DCFSA Plan works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.



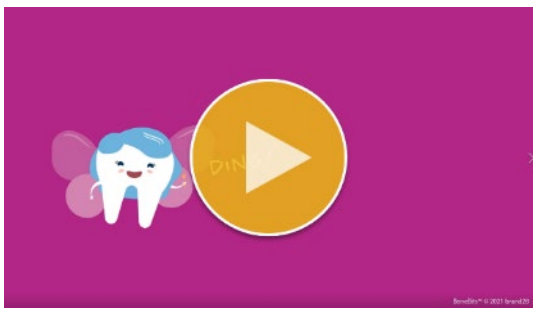
Dental

Our Plans

BCBSIL Dental PPO Plan

BCBSIL Dental HMO Plan

BlueCross BlueShield of Illinois



Click to play video

Why sign up for dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive care** includes exams, cleanings and sealants.
- **Basic/Restorative** care focuses on repair and restoration with services such as fillings and simple extractions
- **Major care** goes further than basic and includes crowns, bridges, and root canals
- **Orthodontia** care is for children up to the age of 26.

Dental PPO

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. Coverage is provided by BlueCross BlueShield of Illinois.

Benefit	In Network	Out of Network
Annual deductible	**Individual:** $100 **Family:** $200	**Individual:** $100 **Family:** $200
Calendar Year maximum	$2,000 per individual	$2,000 per individual
Diagnostic & preventive	Plan pays 100%	Plan pays 100%
Basic services	Plan pays 80% after deductible	Plan pays 80% after deductible
Major services	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia	Plan pays 50% after deductible **Children:** Covered to age 26 **Adults:** Not covered	Plan pays 50% after deductible **Children:** Covered to age 26 **Adults:** Not covered
Orthodontia lifetime maximum	$1,000	$1,000
Network	BlueCare Dental PPO Network	

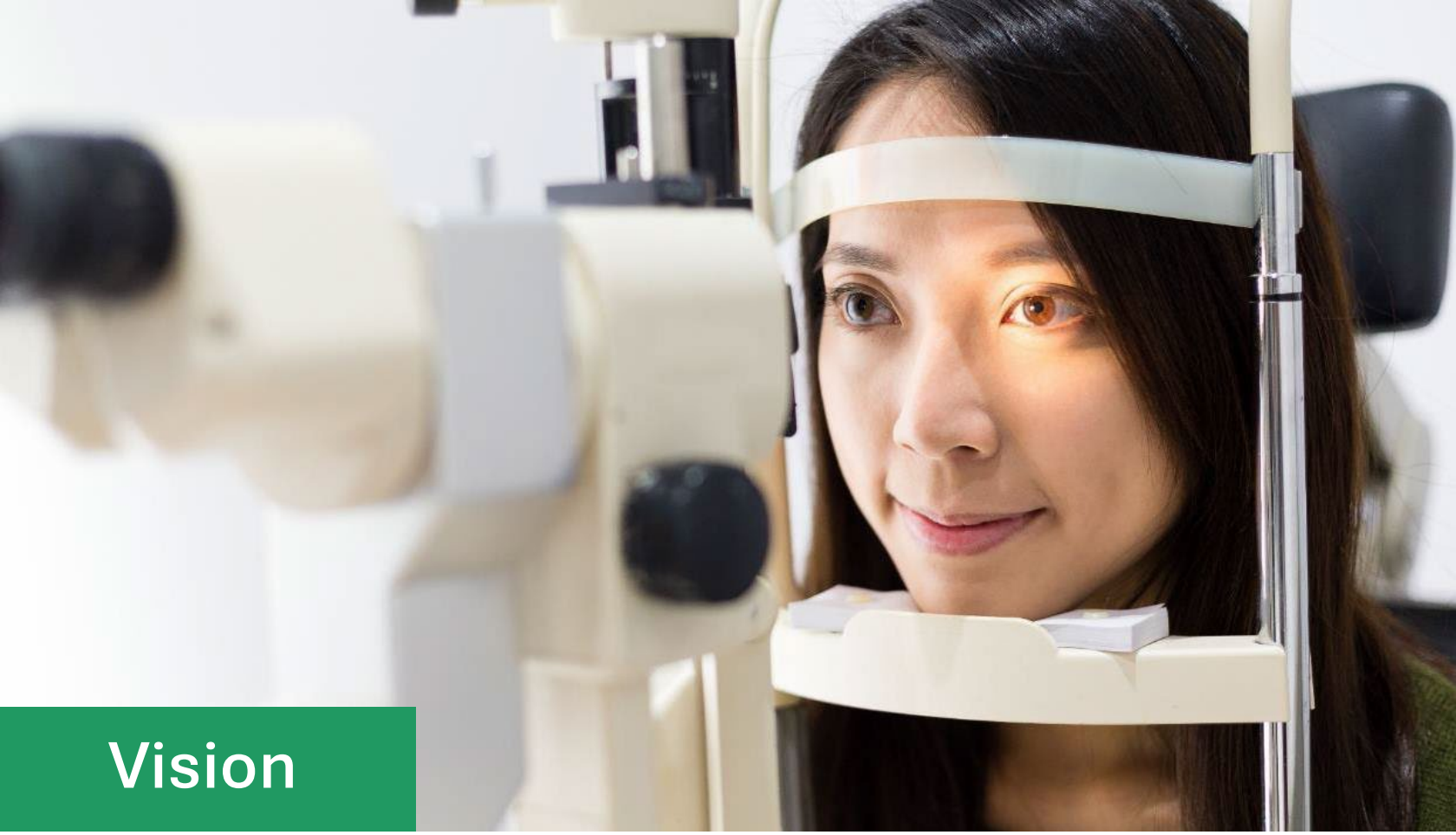
*If you are currently enrolled in the PPO Dental plan and decide to drop it, you will NOT be able to re-enroll in the PPO plan.
*The PPO Dental plan is closed to new enrollees.

BlueCross BlueShield of Illinois

Dental HMO

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. Coverage is provided by BlueCross BlueShield of Illinois.

Benefit	In Network Only Primary Dentist Required
Annual deductible	None
Calendar Year maximum	Unlimited
Diagnostic & preventive	$0
Basic services	$0-$117
Major services	$35-$379
Orthodontia	$1,800 copay **Children:** Covered to age 19 **Adults:** Covered
Orthodontia lifetime maximum	Unlimited
Network	BlueCare Dental HMO Network



Vision

Our Plan

BlueCross BlueShield of Illinois Vision Plan

Click to play video



Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

BlueCross BlueShield of Illinois

Vision

Oak Lawn Community HS Dist. 229 offers a vision plan that allows you to choose from a network of independent optometrists, ophthalmologists, and opticians throughout the country. Routine vision exams can not only correct vision but also detect more serious health conditions. Coverage is provided by BlueCross BlueShield of Illinois.

Benefit	In Network	Out of Network
Exam	$10 copay	$30 allowance
Frequency	Once every 12 months from last date of service	
Frames	$150 allowance, 20% off balance	$75 allowance
Frequency	Once every 12 months from last date of service	
Lenses		
Single Vision Lens	$10 copay	$25 allowance
Bifocal Lens	$10 copay	$40 allowance
Standard Progressives	$10 copay	$55 allowance
Frequency	Once every 12 months (in lieu of contacts) from last date of service	
Contacts		
Conventional	$150 allowance, 15% off balance	$120 allowance
Disposable	$150 allowance	$120 allowance
Frequency	Once every 12 months (in lieu of glasses) from last date of service	
Laser Vision Correction	LASIK and PRK Vision Correction Procedures are available from U.S. Laser Network. In-network benefits include 15% off the retail price or 5% off the promotional price.	
Network	EyeMed's SELECT network	
Member Perks	Hearing care discounts through Amplifon, savings through Glasses.com and ContactsDirect.com	



Important Plan Information

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit costs for 2027
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Your monthly benefit costs

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

Medical	HMO	PPO	HSA
Employee Only	$147.25	$190.68	$155.09
Employee + Spouse	$488.21	$632.16	$514.20
Employee + Children	$468.51	$606.65	$493.45
Employee + Family	$724.86	$938.59	$763.44

Dental	PPO	HMO
Employee Only	$7.51	$4.85
Employee + Spouse	$30.60	$16.03
Employee + Children	$29.36	$17.65
Employee + Family	$45.43	$26.62

Vision	
Employee Only	$0.92
Employee + Spouse	$3.00
Employee + Children	$3.16
Employee + Family	$4.65

Plan contacts and resources

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	BlueCross BlueShield of IL	HMO: (800) 982-2803 HSA & PPO: (800) 458-6024	www.bcbsil.com	HMO: B92875 HSA: PH4925 PPO: PH4920
Pharmacy	Prime Therapeutics	800.423.1973	www.myprime.com	992875
Pharmacy – Mail Order	Express Scripts	833-715-0942	Express-scripts.com/rx	992875
Health Savings Account	AmeriFlex	(888) 868-3539	www.myameriflex.com	AMFOAKLAW
Flexible Spending Accounts	AmeriFlex	(888) 868-3539	www.myameriflex.com	AMFOAKLAW
Dental	BlueCross BlueShield of IL	HMO: (800) 323-7201 PPO: (800) 367-6401	www.bcbsil.com	HMO: D92875 PPO: 099287
Vision	BlueCross BlueShield of IL	(800) 348-4512	www.bcbsil.com	F022824
Employee Assistance Program (EAP)	AllOne Health	(800) 456-6327	perspectives.mylifeexpert.com	Username: Oak503 Password: perspectives

Glossary

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Glossary

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as "ineligible," "not covered," or "not allowed."

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network
Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn't require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician's assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as "immunizations," vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

Important plan information

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on www.olchs.org

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Illinois Consumer Coverage Disclosure Act:** Provides to Illinois employees a list that compares the essential health insurance benefits offered by the employer's group health plan with the essential health benefits regulated by the State of Illinois.

COBRA continuation coverage

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

Deadline for filing lawsuit under ERISA after exhaustion of all claims procedures

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Plan documents

Important documents for our health plan and retirement plan are available on the staff links page on the District's website www.olchs.org and include:

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Judy Amato at 708-741-5604.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Oak Lawn Community High School District #229 Benefits Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.


OAK LAWN COMMUNITY HIGH SCHOOL
District 229 Oak Lawn, Illinois