NIHIP

McHenry School District 15

September 1, 2019–August 31, 2020 Benefit Summary

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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.

Benefits Overview

The District's goal is to provide you with the most comprehensive benefit package possible while balancing our fiscal commitments and obligations.

Benefits Offered

- Medical Insurance
- Dental Insurance
- Employer Paid Life and Accidental Death & Dismemberment (AD&D) Insurance
- Supplemental Life and AD&D Insurance
- Vision Insurance

Who Is Eligible?

Benefits are available to all full-time and eligible part-time employees and their dependents who meet specific eligibility requirements. The plan allows coverage for an employee's legal spouse, civil union partner and/or child(ren), including biological, adopted, or stepchildren, covered from birth to the end of the month they turn age 26; to age 30 for honorably discharged veterans. When enrolling dependents you will be required to submit proof of dependent eligibility. Reference page 5 for a list of accepted Dependent Eligibility Documents.

Active eligible employees, regardless of age, are eligible for benefits under the District's Health Plan.

Important Contact Information

If you would like to find an in-network provider, or ask detailed questions about your benefits, you may contact the insurance companies/service provider directly.

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
PPO Prescriptions	Express-Scripts	800.711.0917	www.express-scripts.com
HMO and HDHP Prescriptions	Prime Therapeutics	800.423.1973	www.bcbsil.com
Dental	Delta Dental	800.942.3772	www.deltadentalil.com
Vision	VSP (PPO and Buy-Up) EyeMed (HMO members)	800.877.7195 844.684.2254	www.vsp.com www.eyemedvisioncare.com/bcbsil
Life and AD&D Insurance	Voya	800.955.7736	www.voya.com

Qualifying Events

Changing your benefits during the year

With the Cafeteria Plan, including employee contributions on a pretax 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 benefits 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. Listed below are some events that qualify for a change in coverage. For a complete list, please reference your Cafeteria Plan document.

- Marriage
- Civil Union
- Divorce or legal separation
- Birth or placement for adoption of a child
- Ineligibility of a dependent
- Loss of other coverage
- Change in your employment status 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. Contact your Human Resources for details to ensure the change is made correctly. If you miss the window for making a change, you will need to wait until the next open enrollment period to make a change.

Dependent Eligibility Documentation

Spouse

- Marriage certificate
- Civil Union certificate

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

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

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

Medical Insurance

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:

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

The Who's Who for the NIHIP Medical Plans

- **Blue Cross and Blue Shield of Illinois is the claims administrator for the PPO, HDHP, and HMO plans.** They determine if you and your dependents are eligible for benefits and process your claims. Contact Blue Cross for questions concerning eligibility, benefits, or status of claim payments. PPO & HDHP Customer Service can be reached at **800.458.6024**, and HMO Customer Service can be reached at **800.892.2803** between the hours of 8:30 a.m. and 6:00 p.m. CST Monday through Friday.
- **Blue Cross has established a Utilization Review program for the PPO.** They work with your doctor to ensure you are getting the most appropriate care, in the appropriate setting for Inpatient Admissions, Coordinated Home Care, Private Duty Nursing and certain Mental Health procedures. Contact them at **800.826.8551**, 7:00 a.m. to 7:00 p.m., CST, Monday through Friday.
- **Express Scripts is your PPO Prescription Benefit Manager.** Retail prescriptions can be obtained through participating pharmacies by presenting your Express Scripts ID Card. Mail order information can be obtained on the Express Scripts website at **www.express-scripts.com**. You can also view the formulary, locate a participating pharmacy, order a refill, etc., on the website. If you have specific questions or issues, please call **800.711.0917**.
- **Prime Therapeutics is your HMO and HDHP Prescription Benefit Manager.** Retail prescriptions can be obtained through participating pharmacies by presenting your Blue Cross ID Card. Mail order information can be obtained on the Blue Cross website at **www.bcbsil.com**. You can also view the formulary, locate a participating pharmacy, order refills, etc., on the website. If you have specific questions or issues, please call **800.423.1973**.

Maximize Your Benefits

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

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. To change your Medical Group call **800.892.2803**.
- Get three months of maintenance medications at the retail pharmacy 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.

Medicare/Retirement

Medicare and Group Health Plan Coverage

When you reach age 65 and you are retired, you have a number of important decisions to make. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, buy a Medigap policy, and/or keep employer or retiree coverage. Understanding your choices may help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you. You can visit **www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your State Health Insurance Assistance Program. To get their telephone number, call **1.800.MEDICARE (800.633.4227**). TTY users should call **877.486.2048**.

Medicare Part B benefits are optional and are available to all beneficiaries when they become entitled to Medicare Part A. Medicare Part B may be purchased by most persons age 65 and over. Although participation in Medicare Part B is optional, the District's health plans will pay as if Medicare Part B has been elected when Medicare is primary. See chart below to determine when Medicare is primary. **Failure to purchase Medicare Part B when Medicare is primary will drastically affect an individual's ability to recover any costs incurred for physician services and other Medicare Part B covered items.**

Medicare Part D (prescriptions)

Those eligible for Medicare are provided a letter of creditable coverage by the District. The letter states that the prescription drug program currently provided by the District's Healthcare Plan meets or exceeds Medicare Part D. Medicare participants are advised that they may select the District's prescription drug plan instead of Medicare Part D. The purpose of the letter is to allow Medicare eligible persons to join Medicare Part D at a later date, if they choose, without paying a late entrant "penalty." This letter will be provided annually each fall.

Who Pays First?			
If You	**Situation**	**Pays First**	**Pays Second**
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare The employer has 20 or more employees	Group Health Plan	Medicare
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree Coverage

Medical Plan Comparison

BCBS Healthcare Plan Administrator

Blue Cross Blue Shield continues to be our healthcare provider. As always, you can go to their website **www.bcbsil.com** to learn more.

	PPO 350	
Deductible[1]	**In-Network**	**Out-of-Network**
Individual	$350	$1,050
Family	$700	$2,100
Coinsurance	90%	70%
Out-of-pocket limit[1]		
Individual	$2,600	$5,200
Family	$5,200	$10,400
Covered Expenses		
Hospital		
Inpatient Services	90%*	70%*
Outpatient Services	90%*	70%*
Emergency Room	$100 copay, then 90%*; copay waived if admitted	
Physician		
Outpatient Surgery	90%*	70%*
Primary Care Office Visits	$20 copay	70%*
Specialist Office Visits	$40 copay	70%*
Preventive Services[2]	100%	70%*
Mental Health		
Office Visits	$20 copay	70%*
Inpatient Services	90%*	70%*
Outpatient Services	90%*	70%*
Other		
X-ray and Lab	90%*	70%*
Therapy: Occupational, Physical or Speech (annual 60-visit limit)	90%*	70%*
Chiropractic[3]	90%* (40 visits per calendar year)	70%* (40 visits per calendar year)
Acupuncture	90%* ($3,000 per calendar year)	70%* ($3,000 per calendar year)
Virtual Visits	$10 copay	N/A
Prescription Drugs	**Express Scripts**	
Retail Pharmacy (30-day supply)	$10 Generic $20 Brand	
Mail Order (90-day supply)	$20 Generic $40 Brand	
Out-of-Pocket Maximum (individual/family)	$2,750/$5,500	
Vision	**VSP**	
Annual Vision Exam	100% after $10 copay with VSP	Reimbursed to $45 max. with VSP

***subject to deductible**

[1] Deductibles and Out-of-Pocket Limit are based on calendar year.

[2] As defined by the US Preventive Services Task Force

[3] Chiropractic care that is medically necessary is covered, maintenance care is not covered.

HDHP 1500		HMO 20
In-Network	**Out-of-Network**	**In-Network Only**
$1,500		N/A
$3,000		N/A
90%	70%	100%
$5,950		$1,500
$11,900[4]		$3,000
90%*	70%*	100%
90%*	70%*	100%
90%*		$100 copay; copay waived if admitted
90%*	70%*	100%
90%* ($125 on average)	70%*	$20 copay
90%*	70%*	$40 copay
100%	70%*	100%
90%*	70%*	$20 copay
90%*	70%*	100%
90%*	70%*	100%
90%*	70%*	Only if referred through PCP, then copay
90%*	70%*	Only if referred through PCP, then copay
90%* (40 visits per calendar year)	70%* (40 visits per calendar year)	Only if referred through PCP, then copay
90%* ($3,000 per calendar year)	70%* ($3,000 per calendar year)	Only if referred through PCP, then copay
90%* ($44 on average)	N/A	Not Applicable
Prime Therapeutics		**Prime Therapeutics**
80%*		$15 Generic, $30 Formulary Brand, $50 Non-Formulary Brand, $50 Self-injectable drugs
80%*		$30 Generic, $60 Formulary Brand, $100 Non-Formulary Brand, $50 Self-injectable drugs
Integrated with Medical		$1,000/$2,000
VSP		**EyeMed**
100% after $10 copay with VSP	Reimbursed to $45 max. with VSP	$0 copay with EyeMed

[4] 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.

NOTE: The summary is only an outline of the benefit schedule. This summary in no way replaces the plan document which outlines all the plan provisions and legally governs the operations of the plans.

Health Savings Account

The District will be offering you a Health Savings Account (HSA) to go along with your High Deductible Health Plan (HDHP) option. 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 healthcare expenses.

Key features include:

- The HSA is a tax-savings vehicle that lets you set aside tax-free money to pay for eligible healthcare expenses. You decide which expenses to pay from your HSA.
- Your balance rolls over year to year. 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 2019, the maximum contribution for individual coverage is $3,500 and the maximum contribution for family coverage is $7,000. 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 healthcare 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 healthcare 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 healthcare expenses?
A. Yes. Your HSA can be used to pay for qualified healthcare 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 healthcare 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 healthcare 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. The plan has lower monthly premiums than other the PPO plans options. In 2019, you are allowed to contribute a single maximum of $3,500, 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 can contribute to the HSA is $7,000 plus an additional $1,000 tax free. If you have limited medical expenses throughout the year, 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 would have build up a bank of $14,000 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 $14,000-$3,000= $11,000. If someone in your family has a chronic illness beginning in the third year, you would have enough money to reach the $3,000 deductible for the year.

Flexible Spending Account

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 **medical and childcare expenses**.

Highlights of an FSA October 1 – September 30

- Pretax money (roughly a 30% savings)
- Every employer has a cap amount (maximum) see below.
- "Use it or lose it."
  - » Essentially, there is an expiration date on your Flexible Savings Account. If you have not spent all the amounts in your flexible spending account by the end of the year, you forfeit the remaining unused balance.

Healthcare

- Individual/Family – $2,700

Dependent Care

- Individual = $2,500/year
- Family = $5,000/year
  (Annual Dependent Care Spending Account Amount. The maximum annual DCSA reimbursement each calendar year may not exceed the lesser of the DCSA reimbursement amount elected for that year or $5,000 or $2,500 for married filling separate returns)
- Reimbursements for allowable expenses (dictated by Section 125 of the Internal Revenue Code) like deductibles, copays, vision expenses, childcare expenses.
- Claims are filed (before December 31, 2020) by the employee to Allied.
  - » Fill out necessary forms and provide receipts, canceled checks, invoices, etc.
  - » Or, use your electronic payment card program (similar to a debit card).

Deciding how much money to fund your flexible savings account can seem intimidating. A good rule of thumb is to take a closer look at your previous healthcare expenses, such as prescription drugs, doctor's visits, eyeglasses, deductibles and copayments, to help you decide the amount to set aside in your FSA.

Blue Cross Programs and Resources

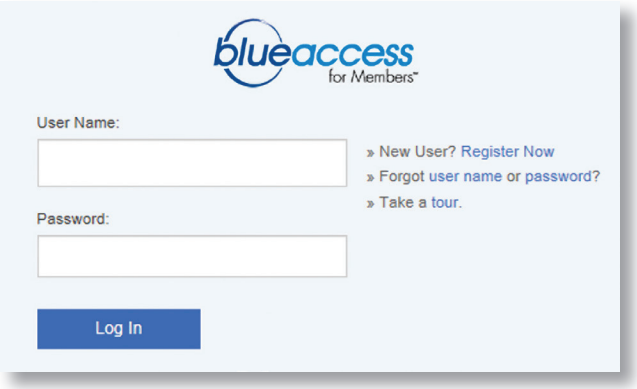
As a Blue Cross and Blue Shield member you have access to a number of valuable programs and resources at no additional cost. For more information, visit **www.bcbsil.com** and login to your Blue Access for Members portal.

Blue Access for Members

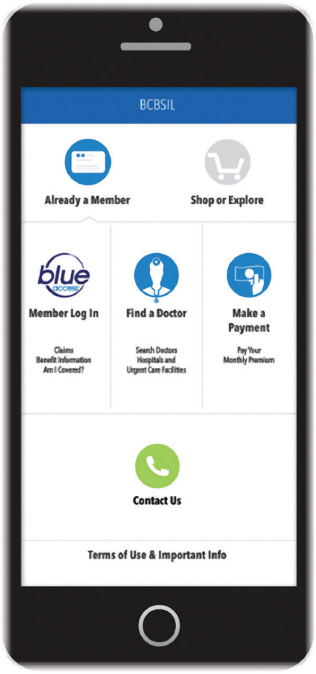
Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the Blue Cross and Blue Shield secure member website, Blue Access for Members (BAM).

With BAM, you can:

- Check the status or history of a claim
- View your benefits
- Confirm who is enrolled and covered on your plan according to Blue Cross
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network



- Request a new ID card – or print a temporary one
- Navigate thru the health and wellness tools
- See what discounts you have available just because you are a member



Blue Access Mobile App

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

From the mobile app you can:

- Register or log in to your secure member site Blue Access for Members to view coverage details, access or request ID cards, check claims status, manage your user profile, use the Message Center and view health and wellness information
- Find a doctor, hospital or urgent care facility
- Shop for insurance and get a quote before applying
- Locate Blue Cross contact information
- Text BCBSILAPP to 33633 to get the app or download at the App Store or Google Play.

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 $10 copay per visit.
- HDHP members pay the cost of the service until the deductible is met and then coinsurance applies. A medical virtual visit costs $44, while an in-person primary care office visit can be upwards of $125. The cost of a behavioral health virtual visit varies. 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.

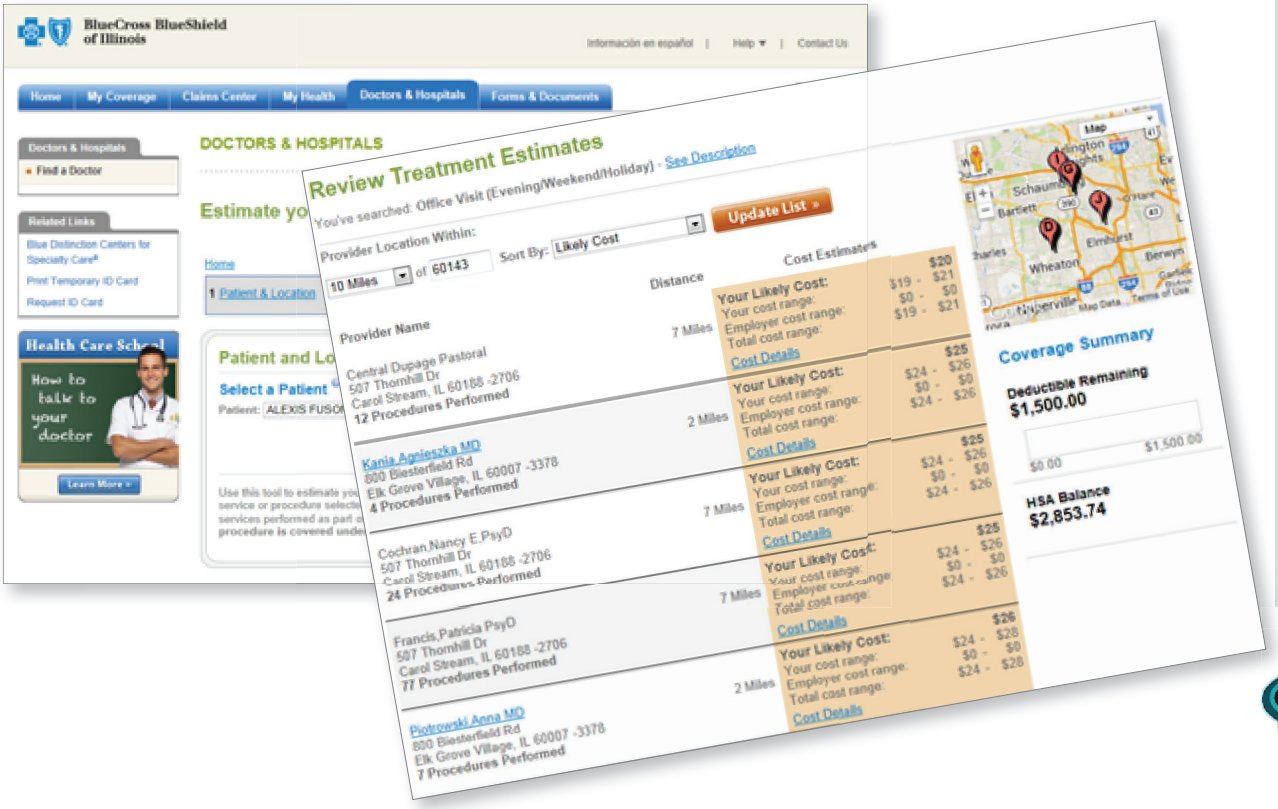
Provider Finder

The Provider Finder from Blue Cross is an innovative tool for helping you choose a provider and estimate healthcare costs. Since cost and quality rating for the same service can greatly vary based on the facility in which the service is preformed Blue Cross offers this tool so you can be well informed as a consumer.

By logging in to Blue Access for Members either online or via your mobile device you can use the Provider Finder to:

- Find a network primary care physician, specialist or hospital
- Filter search results by doctor, specialty, ZIP code, language and gender—even get directions from Google Maps™
- Estimate the cost of a provider's procedures, treatments and tests—and gauge out-of-pocket expenses
- Determine if a Blue Distinction Center for Specialty Care® is an option for treatment
- View patient feedback or add a provider review
- Review providers' certifications and recognitions
- Make an appointment to consult with a provider in select geographic areas
- View clinical quality ratings from Blue Cross as well as independent third parties

The Provider Finder shares information that puts you in charge!



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BlueCross BlueShield of Illinois

Because Your Health Counts

It's Important to Know Where to Go When You Need Care

Sometimes it's easy to know when you should go to an emergency room (ER), at other times, it's less clear. You have choices for receiving in-network care that will work with your schedule and also give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Virtual Visits

There's never a convenient time to get sick. But now you have access to a board-certified doctor around the clock for non-emergency health issues. Connect by mobile app, online video or telephone. Register at **MDLIVE.com/bcbsil** or by calling **888-676-4204**.

Your Doctor's Office

Your own doctor's office may be the best place to go for non-emergency care, such as health exams, routine shots, colds, flu and minor injuries. Your doctor knows your health history, the medicine you take, your lifestyle and can decide if you need tests or specialist care. Your doctor can also help you with care for a chronic health issue, such as asthma or diabetes.

Retail Health Clinic

When you can't get to your regular doctor, walk-in clinics – available in many retail stores – can be a lower-cost choice for treatment. Many stores have a physician assistant or nurse practitioner who can help treat ear infections, rashes, minor cuts and scrapes, allergies and colds.

Urgent/Immediate Care Clinic

These facilities can treat you for more serious health issues, such as when you need an X-ray or stitches. You will probably have a lower out-of-pocket cost than at a hospital ER, and you may have a shorter wait.

Hospital Emergency Room

Any life-threatening or disabling health problem is a true emergency. You should go to the nearest hospital ER or call **911**. When you use the ER for true emergencies, you help keep your out-of-pocket costs lower.

Knowing where to go for care can make a big difference in cost and time. Here's how your options compare†:

	Average Costs	Average Wait Times	Examples of Health Issues	
Virtual Visits Convenient and lower cost	$	10 minutes or less	• Allergies • Cold and flu • Nausea	• Sinus infections • Asthma • Pinkeye
Your Doctor's Office Your doctor knows your medical history best	$	24 minutes*	• Fever, colds and flu • Sore throat • Minor burns • Stomach ache	• Ear or sinus pain • Physicals • Shots • Minor allergic reactions
Retail Health Clinic Convenient, low-cost care in stores and pharmacies	$	15 minutes	• Infections • Cold and flu • Minor injuries or pain • Shots	• Flu shots • Sore and strep throat • Skin problems • Allergies
Urgent Care Clinic Immediate care for issues that are not life-threatening	$$$$	11-20 minutes**	• Migraines or headaches • Cuts that need stitches • Abdominal pain • Sprains or strains	• Urinary tract infection • Animal bites • Back pain
Hospital Emergency Room For serious or life-threatening conditions	$$$$$$	4 hours, 7 minutes***	• Chest pain, stroke • Seizures • Head or neck injuries • Sudden or severe pain	• Fainting, dizziness, weakness • Uncontrolled bleeding • Problem breathing • Broken bones

* Medical Practice Pulse Report 2009, Press Ganey Associates.

** Urgent Care Benchmarking Study Results. Journal of Urgent Care Medicine. January 2012.

*** Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.

Urgent Care or Freestanding Emergency Room

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers and treat most major injuries, except for trauma, but costs are higher. Unlike urgent care centers, freestanding ERs are often out of network and can charge patients up to 10 times more for the same services.[1] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but have EMERGENCY in the facility name.
- Are separate from a hospital but are equipped and work the same as an ER.
- Are staffed by board-certified ER physicians and are subject to the same ER copay.

Find urgent care centers[2] near you by texting[3] **URGENTIL** to **33633**.

Need help finding a network provider?

Use Provider Finder® at **bcbsil.com** or call the Customer Service number on the back of your member ID card. If you need emergency care, call **911** or seek help from any doctor or hospital right away.

† Relative costs described are for independently contracted network providers. Costs for out-of-network providers may be higher.

[1] The Texas Association of Health Plans.

[2] 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.

[3] Message and data rates may apply. Read terms, conditions and privacy policy at bcbsil.com/mobile/text-messaging.

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Blue Distinction for PPO and HDHP Members: 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 healthcare. Its goal is to help consumers find specialty care on a consistent basis, while enabling and encouraging healthcare 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.

24/7 Nurseline for PPO and HDHP Members

Around-the-Clock, Toll-Free Support

Health concerns don't always follow a 9-to-5 schedule. Fortunately, registered nurses are on call at **800.299.0274** to answer your health questions, wherever you may be, 24 hours a day, seven days a week.

The 24/7 Nurseline's registered nurses can understand your health concerns and give general health tips. Get trusted guidance on possible emergency care, urgent care, family care and more.

When should you call?

The toll-free Nurseline can help you or a covered family member get answers to health problem questions, such as:

- Asthma, back pain or chronic health issues
- Dizziness or severe headaches
- High fever
- A baby's nonstop crying
- Cuts or burns
- Sore throat

Plus, when you call, you can access an audio library of more than 1,000 health topics—from allergies to women's health—with more than 600 topics available in Spanish.

Note: For medical emergencies, call 911 or your local emergency services first. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

HMO Members ask your Medical Group what number you should call in a pinch for support when you are unsure if you should come in and it is after hours.

Special Beginnings® for PPO Members

Special Beginnings can help you better understand and manage your pregnancy. Available at no additional cost, this maternity program supports you from early pregnancy until six weeks after delivery through:

- 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.
- Special Beginnings Online is an additional resource that provides information for each week of your pregnancy. The site can be accessed through Blue Access for Members℠.

Take good care of yourself and your baby—enroll in Special Beginnings today!

Enrollment is easy and confidential. Just call **888.421.7781**, 8 a.m. – 6:30 p.m., CT.

Blue Care Connection for PPO and HDHP Members

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 healthcare 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 healthcare 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 your 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 onetime 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 Discount Programs

With this program, you can save money on healthcare 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 Vision Care network of contracted providers gives you the flexibility to get the in-network benefits from thousands of independent and retail providers. For more information, visit **eyemedexchange.com/blue365** or call EyeMed's automated help line at **866.273.0813**.
- **Davis Vision –** You can save on eyeglasses as well as contact lenses, exams and accessories. The Davis Vision group is made up of national and regional retail stores as well as local eye doctors. Save on laser vision correction through the TLC/ TruVision group.
- **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 your 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 3- 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.

Express Scripts Resources for PPO Members

If you are an HMO or HDHP member keep in mind that your prescription vendor is Prime Therapeutics and you can do all the same things through your BCBS BAM Site!

Express Scripts Mobile

Information in the palm of your hands!

- Claims History – View your past prescription activity and payment details
- Medicine Cabinet – Manage prescriptions and check for drug interactions
- Refills & Renewals – Refill and renew home delivery prescriptions
- Order Status
- Pharmacy Care Alerts – Personalized alerts for your treatment plan
- Locate a Pharmacy – Find the one closest to you
- Switch to Home Delivery – Save the runaround, and maybe some money
- Drug Information – Get more detailed medication info
- Prescription ID Card
- My Rx Choices – Find lower-cost options under your plan

To download the app today, visit the app store or visit **Express-Scripts.com/mobileapp**.

Express Scripts Web

Get the most from our prescription benefit through **www.express-scripts.com**.

- Prescriptions and Benefits
  - » Track your prescriptions and home delivery refills
  - » Refill and renew many prescriptions automatically with Worry-Free Fills
  - » View claims, balances and prescription history
- My Account
  - » Receive online alerts if there's a prescription-related safety issue
  - » Search information about any drug on the market
  - » Find lower-cost options
- Health Resource Center – Connect with pharmacists who specialize in medications used to treat long-term health conditions like:
  - » Cardiovascular disease
  - » Diabetes
  - » Bleeding disorders
  - » Other complex and chronic conditions

Prime Therapeutics Resources for HMO and HDHP Plan Members

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 **www.bcbsil.com** or **www.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.

Dental Insurance

When it comes to the health of your teeth and gums, preventive dental care is important, no matter your age. Semi-annual dental exams and cleanings help to prevent or detect complex conditions that could potentially lead to periodontal surgery, root canals, extractions and fillings to lower your potential financial impact.

The ADA recommends the following steps for good dental health:

- Brush twice a day
- Replace your toothbrush every three or four months
- Floss daily
- Eat a balanced diet and limit sugar intake
- Visit your dentist regularly for dental exams and cleanings

Semi-annual dental checkups are important, no matter your age.

Delta Dental PPO Plan – Offers the luxury and convenience of choice. You choose which dental professionals you and your family see. You can find a provider and look up additional information at **www.deltadentalil.com**. If you have any questions regarding claims information, please call **800.942.3712**.

Dental Plan Benefits	
Benefit	**Delta Dental PPO | Delta Dental Premier | Out-of-Network**
Annual Benefit	$1,200
Ortho Lifetime Benefit	$1,200
Annual Deductible Per Person not to exceed $100 per family	$50
Preventive** (Oral exams, Screenings, X-Rays)	100%
Basic Services (Fillings, Simple Extractions)	80%
Major Restorative (Dentures, Oral Surgery)	50%
Orthodontia (for dependent children under age 19)	50%

*Non-Network benefits are paid based on what is usual and customary. Non-network services are generally covered less than services from in the network.

**Not subject to deductible.

When it comes to pearly whites, everyone wants to save a little green. With the Delta Dental PPOSM network, you'll get the coverage you need at a lower out-of-pocket costs. Here's why.

When dentists join Delta Dental's PPO network, they agree to accept Delta Dental's established PPO fees for services as payment in full. On average, patients save 30 percent on the fee a Delta Dental PPO dentist would typically submit for a claim. Delta Dental PPO network dentists have also agreed not to "balance bill" patients. That means they can't bill you for the difference between what they usually charge and the Delta Dental established PPO fee. Delta Dental Premier® is a safety net for our Delta Dental PPO network. You will pay more out-of-pocket with a Delta Dental Premier dentist compared to a Delta Dental PPO dentist. However, you may save more money with a Delta Dental Premier dentist compared to a non-network dentist. Delta Dental Premier dentists agree to our maximum plan allowances as payment in full, which may be lower than what a dentist would typically charge.

Example savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Dental Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount you Pay	Your Total Cost Savings
PPO Network	$1,200	$750	50%	$375	$0	$375	$450
Premier Network	$1,200	$975	50%	$487.50	$0	$487.50	$225
Out-of-Network	$1,200	$975*	50%	$487.50	$225	$712.50**	$0

Delta Dental PPO Network

Delta Dental PPO network dentists have agreed to accept $750 as payment in full for the $1,200 service, a savings of $450 compared to using a non-network dentist. In this example, the Delta Dental plan covers 50 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $375 and you'll pay $375.

Delta Dental Premier® network

Delta Dental Premier network dentists have agreed to accept $975 as payment in full – a savings of $225 compared to using a non-network dentist. In this example, your Delta Dental plan covers 50 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $487.50 and you'll pay $487.50. That's an extra $112.50 tacked on to your share of the bill when compared to what you would have paid with a PPO dentist.

Out-of-Network

Out-of-network dentists have not agreed to accept a lower fee as payment in full and can bill the full $1,200. In this example, non-network dentists are paid off the Delta Dental Premier maximum plan allowance, so the maximum allowed fee is limited to $975*. The dentist can bill you the difference between the maximum allowed fee and what they typically charge.** The Delta Dental plan would cover 50 percent of the $975, paying $487.50. You would be left with the other half of $487.50 plus the $225 difference between the dentist's usual fee and Delta Dental's maximum allowed fees. You would pay a total of $712.50.

As you can see, it pays to use a Delta Dental PPO dentist. Visit **deltadentalil.com** today to find participating dentists in your area. You can also download our free Delta Dental mobile app, available for Apple and Android devices, to find dentists and gauge the cost of common dental treatments using the Dental Care Cost Estimator tool.

This information is for illustrative purposes only and assumes the deductible has been met and the annual maximum has not been reached. There are some limitations on the expenses for which your dental plan pays. If you have specific questions regarding benefit coverage, limitations, exclusions or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact Delta Dental of Illinois. For specific fees and costs for a certain procedure, you can request a pre-estimate from your dentist.

Life and AD&D Insurance

Basic Life and AD&D Insurance

The District pays 100% of the premium for basic employee Life and Accidental Death and Dismemberment (AD&D) for benefit eligible employees. The below are included features:

- Conversion Option
- Waiver of Premium
- Accelerated Benefit for the Terminally Ill

Voluntary Life and AD&D Insurance

Employees may elect to purchase additional Life insurance in $10,000 increments with a minimum of $20,000 and a maximum of $500,000. Newly eligible employees have a guaranteed issue amount of up to $100,000, no medical questions required. If electing over the guaranteed issue amount, or when electing coverage when not first eligible, you will be required to complete evidence of insurability (medical questions). Additional AD&D insurance can be purchased up to $250,000 with no EOI required. Spouse voluntary insurance can be purchased at the same amount as the employee, not to exceed 100% of the employee's basic and voluntary coverage amount. New eligible spouses are guaranteed up to $20,000 in coverage. If electing over the guaranteed issue amount, or when electing coverage when not first eligible, your spouse will be required to complete evidence of insurability. Employees can also purchase voluntary child life insurance coverage; either $5,000 or $10,000. Dependent children coverage cannot exceed 50% of the employee's elected coverage amount and are not eligible for AD&D insurance.

Life Insurance benefits will begin to reduce to 70% on the plan year after your 70th birthday.

Employee/Spouse Age	Rate per $1,000 per month
<20-24	$0.04
25-29	$0.04
30-34	$0.06
35-39	$0.08
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.41
60-64	$0.57
65-69	$1.04
70-74	$1.68
75-79	$2.06
Personal AD&D	$0.03

Dependent Child	Rate per month
$5,000 in coverage	$1.25
$10,000 in coverage	$2.50

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

Vision Insurance

VSP helps you to keep you and your eyes healthy. As the only national not-for-profit vision care company, VSP helps you:

- **Save money.** Did you know that VSP members get the best value and the lowest out-of-pocket costs, saving them an average of $330 per year?
- **Stay healthy.** Annual eye exams are important to your overall health and can detect chronic conditions, like diabetes and high cholesterol.
- **Look great.** From classic styles to the latest designer frames, you will find hundreds of options for you and your family. Plus, get an extra $20 to spend when you choose a featured frame brand.

Visit **vsp.com** to get information about VSP or call **800.877.7195**.

If you are on the District's HMO plan, you can have an annual eye exam and a $175 allowance towards frames or $125 allowance towards contact lenses every 24 months at no cost to you through an EyeMed Vision provider. To find an EyeMed Vision provider please login to **www.eyemedvisioncare.com/bcbsil** or call **844.684.2254**.

Your Coverage with a VSP Provider			
Benefit	**Description**	**Copay**	**Frequency**
WellVision Exam®	Focuses on your eyes and overall wellness	$20 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $170 allowance for a wide selection of frames • $190 allowance for featured frame brands • 20% savings on the amount over your allowance	Combined with exam	Every 12 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses » Anti-reflective Coatings » UV Protection » Scratch-Resistant Coatings • Average savings of 20-25% on other lens enhancements	$0 $95-$105 $150-$175	Every 12 months
Contacts (Instead of Glasses)	• $150 allowance for contacts; copay does not apply; contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Primary EyeCare	• Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed.
Extra Savings	• **Glasses and Sunglasses**—Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	• **Retinal Screening**—No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.		
	• **Laser Vision Correction**—Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Your Coverage with Out-of-Network Providers	
Exam	Up to $45
Frame	Up to $70
Single Vision Lenses	Up to $30
Lined Bifocal Lenses	Up to $50
Lined Trifocal Lenses	Up to $65
Progressive Lenses	Up to $50
Contacts	Up to $105

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Glossary of Employee Benefit Terms

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 Carryover. 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 healthcare 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, January through December. (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 healthcare 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.

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 January 31, 2019. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268
GEORGIA – Medicaid
www.medicaid.georgia.gov Click on Health Insurance Premium Payment (HIPP) 404.656.4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864

IOWA – Medicaid
http://dhs.iowa.gov/hawk-i 800.257.8563
KANSAS – Medicaid
http://www.kdheks.gov/hcf 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov 800.635.2570
LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739 or 651.431.2670

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
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dwss.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll-Free:800.852.3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462

RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov 855.697.4347
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 800.562.3022, ext. 15473
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/ 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2019, 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 12/31/19)

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 physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

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 the 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 health and claims records
- Correct your health and claims records
- 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:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the healthcare treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and 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 a copy of health and claims records

- You can ask to see or get a copy of your health and claims records 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records 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 consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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.

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 healthcare 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 3.
- 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. 20201, 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

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

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 healthcare 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.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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 that we may in writing. If you tell us we may, you can 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 may 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 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

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

Eligibility for 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

McHenry SD 15 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. McHenry SD 15 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

McHenry SD 15

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 McHenry SD 15 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, 1011 N. Green Street, McHenry, IL 60050.** 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. 20201
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 لغة، فإن الخدمات المساعدة اللغوية المجان تتوافر لك. برقم اتصل 1-877.696.6775.

(Russian) ВНИМАНИЕ: Если вы говорите на русскомязыке, то вамдоступныбесплатные 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.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

19GBS31776A