NIHIP

Mundelein School District 75

September 1, 2025 – August 31, 2026 Benefit Summary

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

Eligibility

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
- Vision Insurance
- Employer Paid Life and Accidental Death & Dismemberment (AD&D) Insurance
- Supplemental Life and AD&D Insurance
- Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)
- Long-Term Disability (LTD)

Who Is Eligible?

Benefits are available to all full-time employees and their dependents who meet specific eligibility requirements. Full-time employees are defined as follows: Certified Staff .5 FTE or more prorated by percentage of time employed. Educational support staff employees who regularly work thirty-five (35) or more hours per week including extra duty (i.e. bus duty; lunch duty, etc.) receive full benefits as outlined below. Employees who regularly work twenty-five (25) to thirty-four (34) hours per week receive benefits prorated as determined by the percent of their regular hours divided by 35. 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
Medical PPO and HDHP	BCBS	855.705.7279	www.bcbsil.com
Medical HMO	BCBS	800.892.2803	www.bcbsil.com
PPO, HDHP and HMO Prescriptions	Prime Therapeutics	855.457.0007	www.myprime.com
Dental	MetLife	800.942.0854	www.metlife.com/mybenefits
Vision	VSP EyeMed Vision	800.877.7195 844.684.2254	www.vsp.com www.eyemedvisioncare.com/bcbsil
Flexible Spending Account (FSA)	EBC Flex	800.346.2126	www.ebcflex.com
Health Savings Account (HSA)	EBC Flex	800.346.2126	www.ebcflex.com
Health Reimbursement Account (HRA)	EBC Flex	800.346.2126	www.ebcflex.com
Employee Assistance Program (EAP)	Perspectives	800.456.6327	www.perspectivesltd.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 30 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 30 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

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

Guardianship

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

Court-Ordered Medical Coverage

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

Child Age 26 or Older

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

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 and HDHP Customer Service can be reached at **855.705.7279**, 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 and HDHP plans.** 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.
- **Prime Therapeutics is your PPO, HDHP and HMO 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 drug list, locate a participating pharmacy, order refills, etc., on the website. For specific pharmacy questions or issues members may 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 and HDHP 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 by calling the number on the back of your ID card. Requests made prior to the 15th of the month will be effective the 1st of the following month.
- 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 Plan 600A with HRA		PPO Plan 750	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
DEDUCTIBLE[1]				
Individual	$600	$1,200	$750	$1,500
Family	$1,200	$2,400	$1,500	$3,000
Coinsurance	90%	70%	80%	60%
OUT-OF-POCKET LIMIT[1]				
Individual	$4,400	$8,000	$3,800	$6,800
Family	$8,800	$16,000	$7,600	$13,600
Lifetime Maximum	Unlimited		Unlimited	
Covered Expenses				
HOSPITAL SERVICES				
Inpatient Services	90%*	70%*	80%*	60%*
Outpatient Services	90%*	70%*	80%*	60%*
Inpatient Admission Copay (Annual 5 visit max copay)	$150 copay, then 90%*	$150 copay, then 70%	$150 copay, then 80%*	$150 copay, then 60%
Emergency Room	$150 copay and 90%*; inpatient copay applies if admitted		$150 copay and 90%*; inpatient copay applies if admitted	
NEW! **PHYSICIAN**				
Inpatient Surgery	90%*	70%*	80%*	60%*
Outpatient Surgery	90%*	70%*	80%*	60%*
Primary Care Office Visits	$30 copay[2]	70%*	$30 copay[2]	60%*
Specialist Office Visit	$50 copay[2]	70%*	$50 copay[2]	60%*
Preventive Services**	100%	70%*	100%	60%*
OTHER				
Therapy: Speech, Occupational and Physical[1] (annual 60 visit limit for PPO and HDHP)	90%*	70%*	80%*	60%*
X-ray and Lab	90%*	70%*	80%*	60%*
Chiropractic[1,3] (annual 35-visit limit)	90%*	70%*	80%*	60%*
Ambulance	90%*	70%*	80%*	60%*
Acupuncture[1,4] ($3,000 annual benefit)	90%*	70%*	80%*	60%*
Virtual Visits	$10 copay[2]	N/A	$10 copay[2]	N/A
PRESCRIPTION DRUGS	**Prime Therapeutics**		**Prime Therapeutics**	
Retail Pharmacy (30-day supply)	$15 Generic; $40 Preferred Brand; $60 Non-Preferred Brand; $100 Specialty		$15 Generic; $40 Preferred Brand;, $60 Non-Preferred Brand; $100 Specialty	
NEW! Pharmacy or Mail Order (90-day supply)	$30 Generic; $80 Preferred Brand; $120 Non-Preferred Brand; $100 Specialty		$30 Generic; $80 Preferred Brand; $120 Non-Preferred Brand; $100 Specialty	
Prescription Out-of-Pocket Limit (single / family)	$2,750 / $5,500		$2,750 / $5,500	
VISION	**VSP**		**VSP**	
Annual Vision Exam	100% after $10 copay w/ VSP	Reimbursed up to $45 w/ VSP	100% after $10 copay w/ VSP	Reimbursed up to $45 w/ VSP
HEARING BENEFIT	One device per ear every 24 months		One device per ear every 24 months	

*Subject to deductible and coinsurance.

**As determined by the USPSTF, see plan booklet for complete details.

1 Deductible, Out-of-Pocket, Chiropractic, Acupuncture, and therapy limits are based on a calendar year.

2 Copays do not apply towards the annual deductible. Copays apply towards the out-of-pocket limit. Copays apply only to office visit charge, not to misc. expense incurred during visit.

3 Chiropractic care that is medically necessary is covered; maintenance care is not covered.

4 See plan booklet or contact BCBS for approved providers.

5. If you are covering dependents and enrolled in the HDHP plan, please note: once a family member meets the individual out-of-pocket limit, coinsurance benefits begin for that individual. No individual will contribute more than the individual out-of-pocket amount to the family out-of-pocket amount.

PPO Plan 1200 with HRA		HDHP Plan 1650 with HSA		HMO 30 Illinois	Blue Advantage HMO 30
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
$1,200	$2,400	$1,650		N/A	N/A
$2,400	$4,800	$3,300		N/A	N/A
80%	60%	90%	70%	100%	100%
$4,250	$7,700	$6,350		$1,500	$1,500
$8,500	$15,400	$12,700[5]		$3,000	$3,000
Unlimited		Unlimited		Unlimited	Unlimited
80%*	60%*	90%*	70%*	100%	100%
80%*	60%*	90%*	70%*	100%	100%
$150 copay, then 80%*	$150 copay, then 60%	90%*	70%*	$150 copay	$150 copay
$150 copay and 90%*; inpatient copay applies if admitted		90%*	90%*	$150 copay; inpatient copay applies if admitted	$150 copay; inpatient copay applies if admitted
80%*	60%*	90%*	70%*	100%	100%
80%*	60%*	90%*	70%*	100%	100%
$30 copay[2]	60%*	90%* (average $44/visit)	70%*	$30 copay	$30 copay
$50 copay[2]	60%*	90%*	70%*	$50 copay	$50 copay
100%	60%*	100%	70%*	100%	100%
80%*	60%*	90%*	70%*	Only if referred through PCP, then copay	Only if referred through PCP, then copay
80%*	60%*	90%*	70%*	100%	100%
80%*	60%*	90%*	70%*	Only if referred through PCP, then copay	Only if referred through PCP, then copay
80%*	60%*	90%*	70%*	100%	100%
80%*	60%*	90%*	70%*	Only if referred through PCP, then copay	Only if referred through PCP, then copay
$10 copay[2]	N/A	90%* ($44 on average)	N/A	Check with your Medical Group	Check with your Medical Group
Prime Therapeutics		**Prime Therapeutics**		**Prime Therapeutics**	**Prime Therapeutics**
$15 Generic; $40 Preferred Brand; $60 Non-Preferred Brand; $100 Specialty		80% after deductible		$20 Generic, $40 Preferred Brand, $70 Non-Preferred Brand,	$20 Generic, $40 Preferred Brand, $70 Non-Preferred Brand,
$30 Generic; $80 Preferred Brand; $120 Non-Preferred Brand; $100 Specialty		80% after deductible		$40 Generic; $80 Preferred Brand; $140 Non-Preferred Brand	$40 Generic; $80 Preferred Brand; $140 Non-Preferred Brand
$2,750 / $5,500		Combined with Medical		$1,000 / $2,000	$1,000 / $2,000
VSP		**VSP**		**EyeMed**	**EyeMed**
100% after $10 copay w/ VSP	Reimbursed up to $45 w/ VSP	100% after $10 copay w/ VSP	Reimbursed up to $45 w/ VSP	100% w/ EyeMed	100% w/ EyeMed
One device per ear every 24 months		One device per ear every 24 months		One device per ear every 24 months	One device per ear every 24 months

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

Mental Health Resources

Mental Health Resources

ALL Employees and Dependents Including those NOT enrolled in one of the District's Medical Plans

ALL Mundelein SD 75 employees and those living in their household have access to mental health services through the District's Employee Assistance Program, Perspectives. Perspectives has Masters and PhD level Counselors available 24/7 at **800.456.6327** to assist with:

- Emotional Wellbeing – Stress, Anxiety, Depression, Grief & Loss, Addiction, Communication, Eating Disorders, Managing Work/Family and Trauma/Abuse

Perspectives also offers many on-line resources including articles, videos, webinars and links to additional resources addressing topics such as:

- Child, Elder and Family Care, Legal/Financial, Emotional Wellbeing, Health & Wellness, Smoking Cessation, and Career Resources

To access Perspective's on-line resources visit www.perspectivesltd.com

Enter the Company Access Code: **MUN502**

Employees and Dependents enrolled in the District's BlueCross BlueShield HMO IL or BAHMO Plans

Mundelein SD 75 employees and dependents enrolled in the District's BlueCross BlueShield HMO plans should contact their Medical Group/Primary Care Physician for referrals to Mental Health Services.

Employees and Dependents enrolled in the District's BlueCross BlueShield PPO or HDHP Plans

Mundelein SD 75 employees and dependents enrolled in the District's BlueCross BlueShield (BCBSIL) PPO or HDHP plans have access to the following services through BlueCross BlueShield.

Members may go to:

- A BCBSIL Network Mental Health Provider. The applicable office visit copay would apply per visit.
- A Non-Network provider however, the PPO or HDHP plan's non-network deductible and coinsurance would apply. Also, Non-Network providers are not bound by any BCBSIL contract so the provider may balance bill the member for over and above what BCBSIL allows. (1)
- Members may also access Mental Health services "virtually" though the MDLive program for a $10 Copay per visit if enrolled on the PPO plan, or the full cost of the visit ($44 on average) if enrolled on the HDHP plan. Members can register for MDLive by:
  - Visiting the MDLive website at www.mdlive.com/bcbsil
  - Calling MDLive directly at 888.676.4204
- Members may utilize the BCBSIL Learn To Live® on-line behavioral health program by creating a Blue Access for Members account at www.bcbsil.com. After creating an account just click on Wellness then choose Digital Mental Health. This an on-line tool however, members needing one on one support will be connected with a counselor via phone, text or email.

(1) Members should refer to their benefit booklet or call the number on the back of their BCBSIL ID card for further information regarding the additional costs associated with utilizing a Non-Network provider.

Blue Cross Programs and Resources for PPO and HDHP Members

BlueCross BlueShield of Illinois

Blue Access for Members℠

Health care at your fingertips.

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

With BAM, you can:

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

It's easy to get started.

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

SCAN ME

Scan this QR code to visit bcbsil.com.

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BlueCross BlueShield of Illinois

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

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

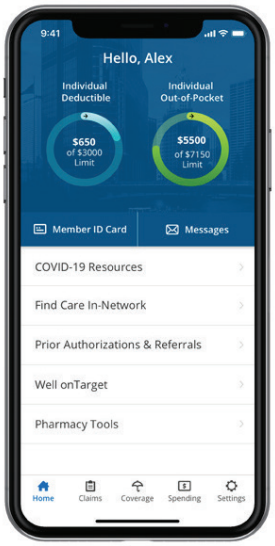
Then, Manage Your Preferences

In the BCBSIL App:

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

Choose the messages and information you want to get:

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



Available in Spanish

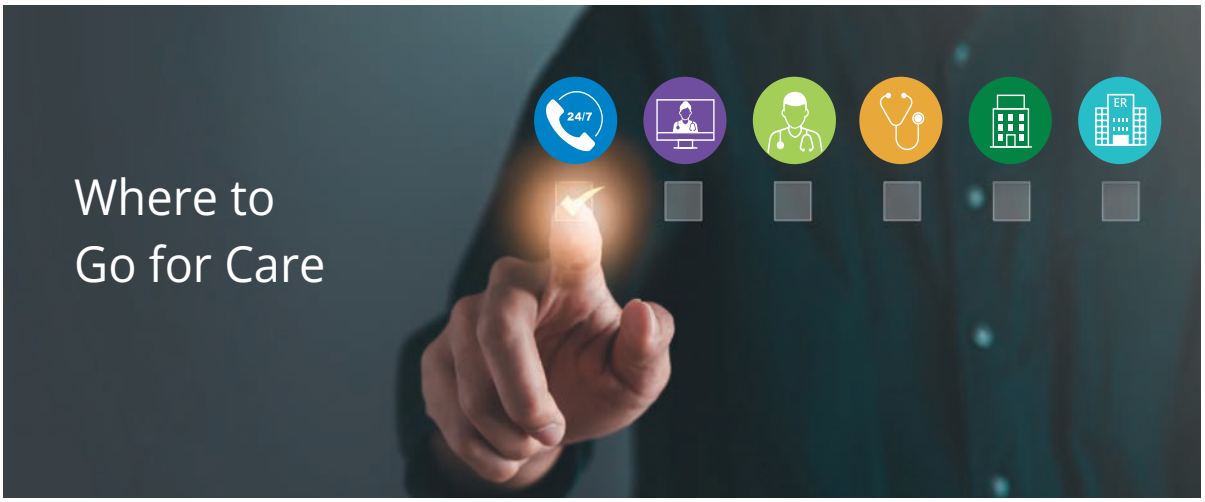
Ready to get started? Text **BCBSILAPP** to **33633**** to get the app.

Download on the App Store

GET IT ON Google Play

Where to Go for Care

BlueCross BlueShield of Illinois



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

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

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

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

24/7 Nurseline[1]

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

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

Virtual Visits[2]

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

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

Where to Go for Care For PPO and HDHP Members

Doctor

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

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

Retail Health Clinic

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

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

Urgent Care Center[4]

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

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

Hospital ER

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

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

Know the Difference: Freestanding ER vs. Urgent Care Center

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

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

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

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

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

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

HMO Members check with your medical group to see where their after hours clinic is located. Keep in mind, if you go to a Walgreen's Healthcare Clinic there is a discount for you!

BCBS Provider Finder Tool

BlueCross BlueShield of Illinois

How Much Does That Cost?

Navigate your plan with Provider Finder®

There's a lot to think about when deciding where to get health care. Look at the table below to see how much prices can change for the same procedure in the same area. Provider Finder is a tool that helps you make the best health care decisions.

Procedure	Provider A	Provider B	Difference
MRI of the Brain	$845	$5,468	**$4,623**
Hysterectomy	$13,755	$37,846	**$24,091**
Hernia Repair	$5,519	$16,763	**$11,244**
Knee Replacement	$12,172	$54,502	**$42,330**

Allowable in-network cost data from providers within a 50-mile radius of Chicago, Illinois. Costs are examples and may not apply to every member's situation.

Provider Finder allows members to:

Check costs before your appointment: Find quality, independently contracted health care providers who charge less.

Find and compare doctors and facilities: Discover local doctors in your network. Check if a facility has been recognized for providing quality care.

Understand your benefits: Learn what you may need to pay based on your plan's copay, coinsurance, deductible and other benefits.*

Learn more about your providers: Read reviews and ratings from other members and share your own.

Go Digital

To use Provider Finder, visit **bcbsil.com** and register or log in to Blue Access for Members℠. Click on the **Find Care** tab, and click on the **Find a Medical Doctor or Hospital** link.

Pre-authorization – For PPO and HDHP Members

BlueCross BlueShield of Illinois

Understand Your Health Plan Before You Get Care to Help Avoid Higher Costs.

Preauthorization (also known as 'prior authorization') means that approval is needed from your health plan before you have certain health tests or services. To help make sure your care is appropriate and avoid unexpected costs, it's important that approval is received **before** you get these services.

Usually, your network provider will take care of preauthorization before the service is performed. But it is always a good idea to check if your doctor has gotten the needed approval.

Your Preauthorization Checklist

Once your health plan coverage starts, you can begin using the resources below. Be a smart health care shopper – use these tools to stay informed about your plan benefits!

1 CONNECT WITH US

Use the information on your Blue Cross and Blue Shield of Illinois (BCBSIL) member ID card to create a Blue Access for Members℠ (BAM℠) account at bcbsil.com. And download the BCBSIL App at the Apple or Google Play store. Both tools can help you keep up with your benefits.

2 KNOW WHAT YOUR PLAN REQUIRES

Log in to BAM and click *My Coverage*. Under the **Referral and Prior Authorization Information** tab, you'll see a list of services that may require preauthorization. You can find a more detailed list of services that require approval under your plan in your benefit booklet. Confirm with your provider that they have gotten approval before your service.

3 TRACK YOUR STATUS

You can check whether your preauthorization has been submitted or approved online. In BAM, go to **My Coverage**, then **Referral and Prior Authorization Information**. Or in the BCBSIL App, click **More**, then **Prior Authorization**.

We want you to get the most out of your health care benefits – let us help! Call the number on the back of your BCBSIL member ID card for questions.

Services That May Require Preauthorization

We want you to be clear about what your health plan covers.

Here is a list of services[1] that may need approval in advance:

- Inpatient hospital stays[2]
- Stays in a facility for rehabilitation, long-term care or skilled nursing care
- Behavioral health care, either in or outside of a hospital
- Some high-cost specialty drugs

Some services you get without a stay at the hospital may also require approval, such as:

- Air ambulance (for non-emergencies)
- CT scans, MRIs and other advanced imaging[3]
  (Members may receive correspondence from AIM Specialty Health, a separate company that provides preauthorization services for BCBSIL.)
- Breast lift or reduction surgery
- Electrical stimulation of the brain, nerves or stomach
- Home health care
- Home infusion
- Hospice
- Some ear, nose or throat services, such as bone conduction hearing aids, cochlear implants or surgery
- Some sleep studies[3]
  (Members may receive correspondence from AIM Specialty Health, a separate company that provides preauthorization services for BCBSIL.)
- Some surgeries of the face, jaw, mouth or teeth
- Some treatments for heart disease[3]
  (Members may receive correspondence from AIM Specialty Health, a separate company that provides preauthorization services for BCBSIL.)
- Some wound care services, such as high-pressure oxygen treatment

You are responsible for calling BCBSIL if you get out-of-network care. Be sure to notify BCBSIL within two days of an emergency, maternity, mental health or substance abuse hospital admission at an out-of-network facility.

For preauthorization or other questions, call the number on the back of your member ID card.

1 Preauthorization requirements vary by plan. Check your benefits booklet or call the Customer Service number on the back of your member ID card for questions about your benefits.

2 In-network inpatient hospitals are required to request preauthorizations on your behalf.

3 AIM Specialty Health is a separate company that provides preauthorization services for BCBSIL. AIM Specialty Health does not provide BCBSIL products and services and is solely responsible for the products and services it provides. Members may receive correspondence from AIM Specialty Health.

237533.0820

MDLive – For PPO and HDHP Members

Get Care When and Where You Need It

- Whether you're at home or traveling, access to an independently contracted, board-certified doctor is available 24/7.
- You can speak to an MDLIVE doctor immediately or schedule an appointment for a time that works for you.
- MDLIVE doctors can help treat many non-emergency conditions.
- A virtual visit may be a better alternative to the emergency room or urgent care center.

Virtual visits may not be available on all plans.

MDLIVE, a separate company, operates and administers the virtual visits program for Blue Cross and Blue Shield of Illinois and is solely responsible for its operations and that of its contracted providers.

How to access MDLive:

Mobile App - "MDLIVE"

Website - **MDLive.com/bcbsil**

Phone - **888.676.4204**

How Virtual Visits Work

CONNECT

Access where mobile app, online video or telephone service is available

INTERACT

Real-time consultation with an independently contracted, board-certified doctor or therapist

DIAGNOSE

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

To register, you'll need to provide your first and last name, date of birth and BCBSIL member ID number.

Member Rewards – For PPO and HDHP Members

BlueCross BlueShield of Illinois

Compare Costs and You May Earn Cash with Member Rewards

Did you know that prices for the same quality medical services can differ by thousands of dollars within the same region and health plan network? Blue Cross and Blue Shield of Illinois provides **Member Rewards**, a program administered by Zelis that offers cash rewards when a lower-cost, quality option is selected.

- Compare it to where you park your car—the $30 lot or the $15 one just a few blocks away.
- Member Rewards allows you to shop for health care services in a similar way, and as the examples in the chart show, you can save money depending on the option you select.
- Best of all, shopping with Member Rewards could help lower your out-of-pocket costs and help get you a cash reward.

Reward Eligible Procedure	Provider A Cost	Provider B Cost
MRI of the Brain	$682	$2,723
Artificial Joint Repair	$17,003	$47,617

Examples shown are for illustration purposes and are not intended to represent costs for procedures in your area.

NIHIP

Program Benefits

Member Rewards uses our Provider Finder® tool to help you:

- Compare costs and quality for numerous procedures such as screenings, scans, surgeries and more
- Estimate out-of-pocket costs
- Earn cash rewards
- Save money and make the most efficient use of your health care benefits
- Consider treatment decisions with your doctors

Most of us look for value when we're shopping — why not apply this practice to shopping for health care services? With Member Rewards, you can reduce your costs and take more control of your health care financial decisions.

How Does It Work?

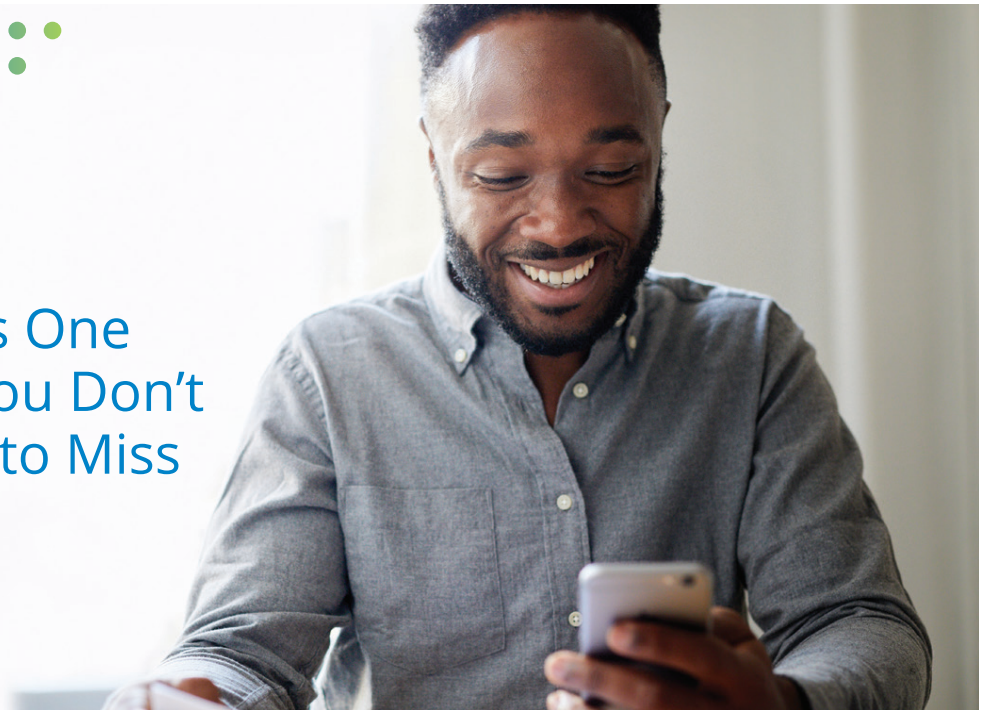
1. Call a **Benefits Value Advisor** 24 hours a day, seven days a week* at the number on the back of your member ID card to find a reward-eligible provider. Or shop online with Provider Finder by visiting **bcbsil.com**, register or log in to Blue Access for Members℠ and select **Find Care**.

2. Get the procedure or service at your chosen reward-eligible provider.

3. Receive a cash reward by check, which will be mailed to your home, after the claim is paid and the provider is verified as reward-eligible.

Questions? Call the number on the back of your member ID card.

BlueCross BlueShield of Illinois



Here's One Call You Don't Want to Miss

If you get a call from Blue Cross and Blue Shield of Illinois (BCBSIL), we're calling to help you take good care of your health. Please answer or call us back.

Your health plan includes support for you and your covered family members from nurses and other medical professionals called health advisors.* This extra help is at no added cost to you.

BCBSIL may call to help you:

- Get the care you need for serious illnesses or injuries
- Have a healthy pregnancy and baby
- If you have been in the hospital or have had a major surgery

Calls from health advisors are not sales calls. We may ask you for information, like your name, date of birth or home address, to make sure that we are talking to the right person.

If we miss you, we will leave a message with a number for you to call us back at your convenience. We're here for you!

Connect with Us – Your Way

You can set the time you want your health advisor to call or send them messages in your Blue Access for Members℠ account.

They can also email or text you helpful information. Any information you share with BCBSIL is confidential, as required by law.

*Health advisors do not replace the care of a doctor. You should talk to your doctor about any medical questions or concerns.

235454.0621

Omada – For PPO and HDHP Members

Omada is an online behavioral counseling program designed to help at-risk individuals combat obesity-related chronic disease. Participants in the Omada program learn how to make modest health changes that could lead to weight loss and reduced risk for type 2 diabetes and heart disease. Learn more and watch the 2-minute video at **omadahealth.com/nihip**.

How do I apply?

Individuals interested in the Omada program can visit **omadahealth.com/nihip** to take a 1-minute risk screener and find out if they meet the clinical enrollment criteria to participate in the program. The risk screener asks a few questions about height, weight, and health conditions. Those who are eligible to enroll will receive an email invitation to join the Omada program.

You'll get

- An Interactive Program that adapts to you
- A wireless smart scale to monitor your progress
- An Omada health coach to keep you on track
- A small online peer group for real-time support

Questions? email support@omadahealth.com, call 888.409.8687, or check out our help center articles at support.omadahealth.com

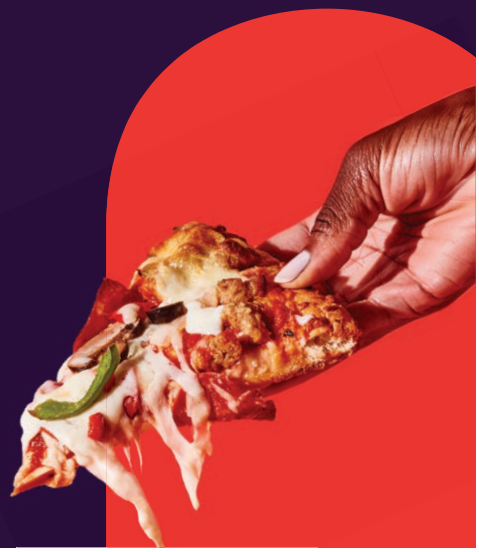
Wondr Health for PPO, HDHP and HMO Members

Clinically-proven weight loss without counting calories

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

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

Go to wondrhealth.com/NIHIP



What is Wondr?

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

*Restrictions and eligibility info can be found at wondrhealth.com/NIHIP

Questions? Visit support.wondrhealth.com

LET'S TALK RESULTS

In as little as 10 weeks:

84% LOST WEIGHT

62% FEEL MORE CONFIDENT

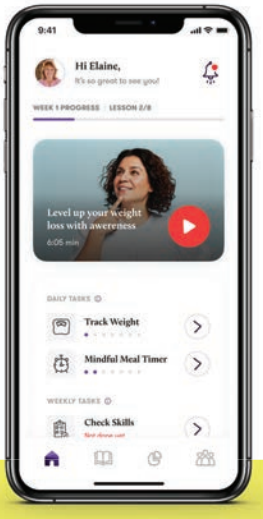
61% HAVE MORE ENERGY

85% FEEL MORE IN CONTROL OF THEIR WEIGHT

68% ARE MORE PHYSICALLY ACTIVE

57% FEEL THEIR MOOD HAS IMPROVED

*Based on Wondr Health Book of Business



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

—Brad M.
WONDR PARTICIPANT

LOST 70 lbs | **GAINED Confidence**

GET IT ON Google Play

Download on the App Store

wondr | NIHIP

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 health care. Its goal is to help consumers find specialty care on a consistent basis, while enabling and encouraging health care professionals to improve the overall quality and delivery of care nationwide.

Use the Blue Distinction Center Finder.

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

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

Blue Distinction Centers for Bariatric Surgery®

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

Blue Distinction Centers for Cardiac Care®

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

Blue Distinction Centers for Transplants®

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

Blue Distinction Centers for Complex and Rare Cancers®

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

Blue Distinction Centers for Knee and Hip Replacement℠

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

Blue Distinction Centers for Spine Surgery®

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

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.

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.

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.

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

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

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

The site can be accessed through Blue Access for Members℠. Download any of the Ovia Health mobile apps from the Apple App Store or Google Play. During sign up, make sure to choose "I have Ovia Health as a benefit." Then select BCBSIL as your health plan and enter the name, "NIHIP". Enrollment is easy and confidential. Just call **855.705.7279**, 8 a.m. – 6:30 p.m., CT.

Wellbeing Management for PPO and HDHP Members

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

Condition Management

Blue Care Advisors, registered nurses or other health care professionals, may contact you if you have certain health challenges or chronic conditions. Through regularly scheduled health counseling and coaching telephone calls, the advisor can help you identify unhealthy behaviors, set wellness goals, adopt healthier habits and learn to manage medical conditions more effectively. The Condition Management programs are voluntary and work together with you, your health plan and your doctor to help identify the best ways to manage your chronic health condition and stay healthy.

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

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

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

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

Lifestyle Management

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

CCEI Care Coordination and Early Intervention

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

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

Care management specialists can:

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

Case Management

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

The individualized approach features:

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

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

Well onTarget℠ for PPO, HDHP and HMO Members

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

Well onTarget features include:

- **Member Wellness Portal –** A comprehensive, adaptable online portal that engages you through useful health resources, goal trackers, tools and more:
  - » Onmyway Health Assessment – Answer survey questions that assess their current health status. The results help identify health risks and define a personalized program with individual wellness goals.
  - » Health and Wellness Content – Online health encyclopedia that educates and empowers through evidence-based, consumer-friendly content.
  - » Onmytime Self-directed Courses – A suite of structured courses to help achieve health and wellness goals. Topics include nutrition, exercise, weight and stress management and tobacco cessation. Reach your milestones and earn Life Points.
  - » Tools and trackers- Interactive tools help keep you on course while making wellness fun. Use a food and exercise diary, symptom checker and health trackers.
  - » Life Points – A rewards program that reinforces positive lifestyle changes, such as more time at the gym or healthier meal choices.
- **Onmyteam Wellness Coaching –** Professionally certified coaches counsel employees on nutrition, physical activity and stress management, fostering sustained involvement through phone contact or secured messaging via the interactive member portal.
- **Fitness Program –** Fitness can be easy, fun and affordable. The Fitness Program is a flexible membership program. Gain unlimited access to a nationwide network of fitness centers. With more than 8,000 gyms on hand, you can work out at any place or at any time. Choose a gym close to home and one near your office.
  - » No long-term contracts required. Membership is month to month with a one-time enrollment fee.
  - » 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)**

BCBS Programs and Resources

Blue365 is just one more advantage you have by being a Blue Cross and Blue Shield of Illinois (BCBSIL) member. With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or preauthorizations.

Once you sign up for Blue365 at **blue365deals.com/bcbsil**, weekly "Featured Deals" will be emailed to you. These deals offer special savings for a short period of time.

Below are some of the ongoing deals offered through Blue365.

EyeMed® | Davis Vision®

You can save on eye exams, eyeglasses, contact lenses and accessories. You have access to national and regional retail stores and local eye doctors. You may also get possible savings on laser vision correction.

TruHearing® | Beltone™ | Start Hearing

You could get savings on hearing tests, evaluations and hearing aids. Discounts may also be available for your immediate family members.

Fitbit®

You can customize your workout routine with Fitbit's family of trackers and smartwatches that can be employed seamlessly with your lifestyle, your budget and your goals. You'll get a 20% discount on Fitbit devices plus free shipping.

Reebok | SKECHERS®

Reebok, a trusted brand for more than 100 years, makes top athletic equipment for all people, from professional athletes to kids playing soccer. Get 20% off select models. SKECHERS, an award-winning leader in the footwear industry, offers exclusive pricing on select men's and women's styles. You can get 30% off plus free shipping for your online orders.

InVite® Health

InVite Health offers quality vitamins and supplements, educational resources and a team of health care experts for guidance to select the correct product at the best value. Get 50% off the retail price of non-genetically modified microorganism (non-GMO) vitamins and supplements.

Dental Solutions℠

You could get dental savings with Dental Solutions. You may receive a dental discount card that provides access to discounts of up to 50% at more than 70,000 dentists and more than 254,000 locations.*

Sun Basket | Nutrisystem®

Help reach your weight loss goals with savings from leading programs. You may save on healthy meals, membership fees (where applicable), nutritional products and services.

Livekick

Livekick is the future of private fitness. Choose from training or yoga over live video with a private coach. Get fit and feel healthier with action-packed 30-minute sessions that you can do from home, your gym or your hotel while traveling. Get a free two-week trial and 30% off a monthly plan on any Live Online Personal Training.

eMindful

Get up to a 50% discount on any of eMindful's live streaming or recorded premium courses. Apply mindfulness to your life including stress reduction, mindful eating, chronic pain management, yoga, Qigong movements and more.

For more great deals or to learn more about Blue365, visit blue365deals.com/bcbsil.

Prime Therapeutics Resources For PPO, HDHP and HMO 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.

- The PPO drug list is the balanced drug list, updated quarterly.
- The HMO drug list is the preferred drug list, updated quarterly.

Use **myprime.com** to:

- Find out if a drug is on your plan's drug list. Using preferred 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

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

Semi-annual dental checkups are important, no matter your age. Dependent dental eligibility now covered to age 26; to age 30 for honorably discharged veterans.

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

A dental ID card is not necessary to receive services or benefits. Please provide your dentist with our Group Dental ID Number 304230 and our Group Name Mundelein School District #75. Just be sure to bring a MetLife Dental Claim Form (which you can get by printing from the website or by calling the Employee Benefit Line) with you to your first appointment, and your dentist will take care of the rest!

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

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

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

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

Dental PPO Plan Benefits	
Annual Benefit	$1,500
Orthodontia Lifetime Benefit (children to age 19)	$1,000
Annual Individual Deductible*	$50
Annual Family Deductible*	$150
Preventive** (cleanings & exams)	100%
Basic Services (fillings, endodontics, periodontics, oral surgery)	80%
Major Services (crowns, bridges, dentures, bruxism appliances, dental implants)	50%
Orthodontia	50%

*Deductibles are calendar year.

**Preventive care not subject to deductible.

To make a change to your medical or dental benefits or flexible spending account, you must experience a qualified life event in accordance with the Flexible Spending Account plan document.

VSP Vision Buy Up Benefit

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and NIHIP - Plan C. Take a look at your VSP vision care coverage.

VSP members save an annual average of

$471*

More Ways to Save

Additional $50 to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

Up to 40% savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Enroll through your employer today.
Questions?
vsp.com or **800.877.7195**

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during an eye exam.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

VSP gives you thousands of in-network choices, including private practice doctors, regional and national optical retail chains, or online at **eyeconic.com**®. You'll get the most out of your benefits at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors · Visionworks

Premier Edge™ Promise

You now have access to the Premier Edge Promise, a worry-free eyewear guarantee. Whether you accidentally break or damage your glasses, your prescription changes, or if you don't love the glasses you chose, you're covered! Visit **vsp.com/zerocopay** for details.

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details. *Based on state and national averages for eye exams and most commonly purchased brands. This chart represents average savings for VSP members at in-network providers. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP 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. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks and Eyeconic are VSP-affiliated companies.

Classification: Restricted

Vision Benefits

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through NIHIP - Plan C. Get the most out of your benefits with low, or no out-of-pocket costs when you visit a VSP network doctor or Premier Edge location.

Provider Network:
VSP Choice
Effective Date:
09/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY WITH PREMIER EDGE DOCTORS	COPAY WITH OTHER VSP NETWORK DOCTORS
COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM®	• Focuses on your eyes and overall wellness • Routine retinal screening • Every plan year*	**$0** $20	$10 $20
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam	$20 per exam
PRESCRIPTION GLASSES		**$25**	**$25**
FRAME+	• $250 Featured Brands frame allowance • $250 Visionworks frame allowance on any frame • $200 frame allowance • 20% savings on the amount over your allowance • $110 Walmart/Sam's Club/Costco frame allowance • Every plan year	Included in Prescription Glasses	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every plan year	Included in Prescription Glasses	Included in Prescription Glasses
LENS ENHANCEMENTS+	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every plan year	$0 $95 – $105 $150 – $175	$0 $95 – $105 $150 – $175
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60	Up to $60
VSP EASYOPTIONS+	**Members can choose one of these upgrades** • Fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or fully covered anti-glare coating • Every calendar year	Included in Prescription Glasses	Included in Prescription Glasses
VSP LIGHTCARE™+	• $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every plan year	$25	$25
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
YOUR MONTHLY CONTRIBUTION	$11.50 Member only	$24.08 Member + 1	$25.77 Member + child(ren)	$41.18 Member + family

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam.....up to $45	Lined Bifocal Lenses.....up to $50	Progressive Lenses.....up to $50
Frame.....up to $70	Lined Trifocal Lenses.....up to $65	Contacts.....up to $105
Single Vision Lenses.....up to $30		

*Plan year begins in September.

VSP Vision Benefit Included Within PPO and HDHP Medical Plan

Northern Illinois Health Insurance Program and VSP provide you with an affordable eye exam.

Doctor Network: You will find the VSP choice providers who's right for you at **www.vsp.com** or by calling **800.877.7195**. Our doctors offer flexible hours, a variety of office settings, and eyewear choices you'll love.

Value and Savings: You'll get great savings on your eye exam and eyewear, and a discount on laser vision correction.

Your Coverage from a VSP Choice Provider	
WellVision Exam® focuses on your eye health and overall wellness Every 12 months	$10 copay
Prescription Glasses Discount	
Lenses	20% discount when a complete pair of glasses is purchased
Frames	20% discount when a complete pair of glasses is purchased
Retinal Imaging	$20 copay
Contacts	15% discount off the contact lens exam (fitting and evaluation)
Out-of-Network	Reimbursed up to $45

EyeMed Vision Care Discount Programs

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

If you are participating in the HMO plan, the vision benefit is administered by EyeMed Vision Care. You are eligible for an annual eye exam at no cost to you and either a $175 allowance towards frames or $125 for contact lenses every 24 months at a participating EyeMed provider.

EyeMed's network of contracted providers gives you the flexibility to get the in-network benefits from thousands of independent and retail providers. No matter which provider you choose, our vision benefits plan is designed to be easy to use. To locate a provider, call EyeMed Vision Care at **844.684.2254** or visit **www.eyemedvisioncare.com/bcbsil**.

In-network providers file claims on your behalf, so you won't have to.

Life Insurance and AD&D

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. Evidence of Insurability (EOI) may be required above a certain benefit level, reference your plan document for details. Additional AD&D insurance can be purchase 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 combined. 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. Dependent children are not eligible for AD&D insurance.

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

Monthly Premium Rates For Employee and Spouse

Per $1,000 of Life Insurance. For additional information, please contact Tina Routledge at **847.949.2700**.

Age (last birthday as of the anniversary date)	Rate
Under age 20	$ .04
20-24	$ .04
25-29	$ .04
30-34	$.06
35-39	$.08
40-44	$.10
45-49	$.15
50-54	$.23
55-59	$.41
60-64	$.57
65-69	$1.04
70-74	$1.68
75+	$2.06

Dependent Children	Rate Per Month
$5,000	$1.25
$10,000	$2.50

The cost is not per child but per all dependent children.

Voluntary Long-Term Disability

Employees are eligible for long-term disability at their expense. For additional information, please contact Tina Routledge.

Voya Bereavement Support

empathy.

Bereavement Support

VOYA®

Bereavement Support

On-demand personalized services includes:

- Custom Care Plan tailored to the family's unique needs
- For each family, a dedicated Care Manager will work with them step-by-step
- Hands-on assistance from and access to the Care Team

Curated bereavement tools include:

- **Obituary creator:** A beautifully written obituary, crafted in minutes
- **Grief resources:** Guided meditations, audio companions, and a journaling tool
- **Help claiming benefits:** Resources and dedicated assistance for claiming survivor or other available benefits, such as those from Social Security or the Veteran's Administration
- **Probate & estate administration:** State-specific guidance and resources on probate process
- **Account closing:** Closing unneeded financial accounts, subscriptions, and memberships
- **Family collaboration:** Intuitive dashboard for family members to share tasks, resources, and progress
- **Secure, scanned document storage:** Storage for important papers in one secured location

How to get started

Navigating a loss can be challenging and knowing where to start can be difficult. Empathy's experienced Care Team is ready to provide support via web, app, or phone.

Beneficiary and loved one support

Have you experienced a loss of someone who had group term life insurance coverage through Voya?

- Call 769-305-2683,
- Log onto join.empathy.com/voya, or
- Download the Empathy app and use referral code: EMP-VOYA

General Care Team support

Have general questions about Empathy?

- Call 251-299-8482 or
- Email: support@empathy.com

Group Name: NIHIP
Policy Number: 280887

How to sign up:

1. Select the appropriate link based on the support you're looking for
2. Enter your name, email address, and a phone number that can receive text messages.
3. Click the "Get Started" button and enter the code contained in the authentication text message.
4. Answer the prompted questions to get support tailored to your needs.

Voya Travel Assistance

Security when you travel

Voya Travel Assistance

We live in a highly connected world where frequent domestic and international travel is the norm

Voya Travel Assistance offers you enhanced security for your leisure and business trips when traveling 100 miles or more from your primary residency or in another country, for trips 180 days or less. You and your dependents will have access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world. Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN.

Group name: Northern Illinois Health Insurance Plan (NIHIP)
Group number: 280887

Emergency Medical Transport Services

- Dispatch of a Physician
- Emergency Medical Evacuation
- Medical Repatriation
- Return of Dependent Children
- Return of Travel Companion
- Vehicle Return Services
- Visit of a Family Member or Friend
- Repatriation of Remains

Medical Assistance Services

- Convalescence Arrangements
- Outpatient & Inpatient Care
- Interpretation Services
- Medical Monitoring
- Medical & Dental Referrals
- Prescription Transfer & Shipping
- Replacement of Medical Devices

Travel Assistance Services

- Emergency Cash Transfer
- Consulate and Embassy Location
- ID Theft Assistance
- Legal Referrals
- Lost Luggage and/or Document Assistance
- Pet Housing and Return
- Pre-Trip Informational Services
- Urgent Message Relay

Security Assistance Services

- Emergency Political Evacuation/ Repatriation
- Location Intelligence App
- Natural Disaster Evacuation

This document is for informational purposes only and describes IMG's general capabilities and a broad overview of the services it offers. The actual services and payments that IMG arranges or provides for you will be determined by your services contract.
ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies

PLAN INVEST PROTECT

VOYA FINANCIAL

NIHIP

If you need emergency or pre-trip services...	Voya Travel Assistance
...use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program. You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described. Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.	Contact Voya Travel Assistance 24 hours a day, 365 days a year for: Emergency Medical Transport, Medical Assistance, Travel Assistance, and Security Assistance Services. **From anywhere in the world:** +1 (317) 659-5841 **Email:** assist@imglobal.com **Visit Online and Register:** imglobal.com/member ☑ Select "Create an account" ☑ Enter referral code: VOYATRAVEL ☑ Click "continue" to enter your personal information, email address, and create your password.

Access Voya Travel Assistance on the go

Be supported on the go with Voya Travel Assistance by downloading the IMG mobile app from the Apple App Store and Android Google Play Store.

How it works

At any time before or during a trip, you may contact Voya Travel Assistance for assistance services. It is recommended that you keep a copy of this summary with your travel documents. Use the wallet card to have convenient access to the numbers that you need.

Exclusions and limitations

Travelers are eligible when traveling 100 miles or more from their primary residence or in another country, for trips 180 days or less.

Voya Travel Assistance shall not be responsible for any claim, damage, loss, costs, liability, or expense which arises as a result of Voya Travel Assistance's inability to contact the Group Policyholder's authorized Contact for any reason beyond Voya Travel Assistance's control or as a result of the failure and/or refusal of the Group Policyholder to authorize services proposed by Voya Travel Assistance.

Medical Transport Service

All transportations must be coordinated by Voya Travel Assistance in order to be eligible. IMG will not be responsible for medical transportations that are not coordinated by Voya Travel Assistance Services are not available to the traveler for sickness, injuries, or losses resulting from:

- Normal childbirth, normal pregnancy (except complications of pregnancy), or voluntary induced abortion
- Traveling for the purposes of securing medical treatment
- A member's mental or nervous condition, unless hospitalized
- Active participation in war and/or terrorism
- Traveling against the advice of a physician

Security Assistance Services

All emergency medical transport, political, natural disaster, or security evacuation services will be coordinated by IMG. Services listed in this brochure are only valid if IMG remains a client of Voya Financial.

Evacuation services are provided to the nearest safe location and then to covered member's resident country, if needed.

Level 4 Restriction: Services will be denied if the Member's destination country is at a Level 4 Travel Advisory (other than for COVID) on the US State Department website at the time of your Scheduled Departure Date to travel there.

Voya Travel Assistance will not be responsible for political or natural disaster evacuations that are not coordinated and provided by Voya Travel Assistance or its security partner.

Voya Travel Assistance is not responsible for any medical expenses incurred by travelers under this quote.

Services are not available to the extent they would expose Voya Travel Assistance or any of its insurers to any sanction, prohibition or restriction under U.N. resolutions or the trade or economic sanctions, laws, or regulations of the E.U., U.K., or U.S.A.
All services are governed by the terms and conditions outlined in the contract between IMG and Voya.

This proposal is for informational purposes only and describes IMG's general capabilities and a broad overview of the services it offers. The actual services and payments that IMG arranges or provides will be determined by the services contract between IMG and Voya. Please review the services contract for complete details and exclusions.

Products and services may not be available in all states.

Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN.

ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies.

For use by Group name: Northern Illinois Health Insurance Plan (NIHIP) group only.

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FSA, HRA, HSA Information

This year Mundelein School District will be offering three different spending accounts for qualified medical expenses: a Flexible Spending Account (FSA), a Health Reimbursement Account (HRA), and a Health Savings Account (HSA).

	FSA	HRA	HSA
What medical plans can I elect?	PPO 600 PPO 750 PPO 1200 HDHP 1650 HMO 30 BA HMO 30	PPO 600 PPO 1200	HDHP 1650
How much can be contributed into the account each year?	$3,300 (medical) $5,000 (dependent care)	Employers are only able to contribute	Single: $4,300 Family: $8,550
When can I make changes to the contribution amount?	Life events or open enrollment	N/A	Whenever you decide
Can funds be carried over from one year to the next?	No	**YES!** The money leftover in your account will rollover every year!	**YES!** The money leftover in your account will rollover every year!

If you have more questions about these medical accounts, please contact Tina Routledge at **847.949.2700**.

Employee Assistance Program (EAP)

Life comes with challenges.

Your Assistance Program is here to help.

Your Assistance Program can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals.

All services are free, confidential, and available to you and your family members. This includes access to short-term counseling and the wide range of services listed below:

Mental Health Sessions
Manage stress, anxiety, and depression, resolve conflict, improve relationships, and address any personal issues. Choose from in-person sessions, video counseling, or telephonic counseling.

Life Coaching
Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and achieve greater balance.

Financial Consultation
Build financial wellness related to budgeting, buying a home, paying off debt, resolving general tax questions, preventing identity theft, and saving for retirement or tuition.

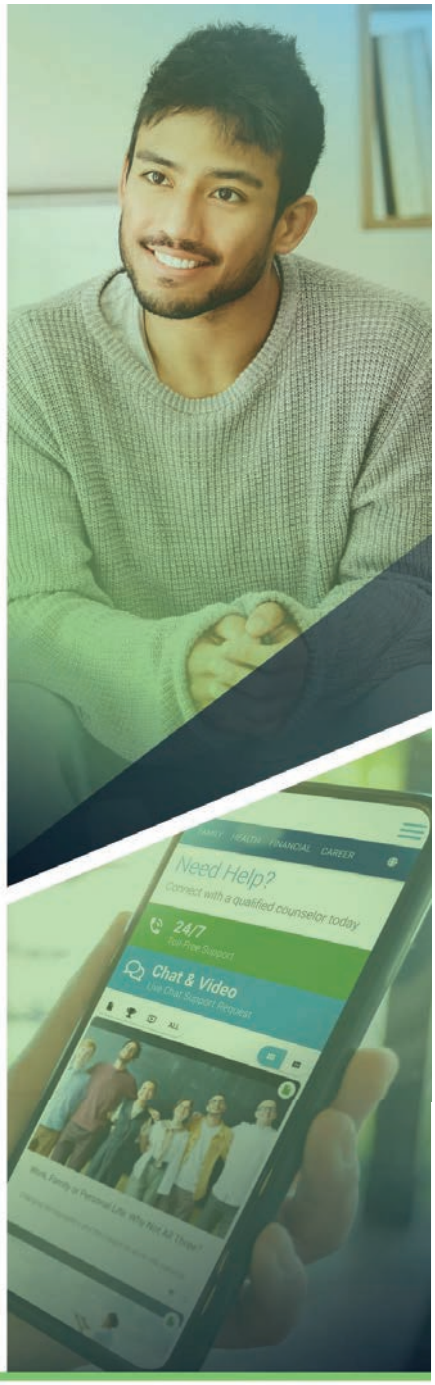
Legal Referrals
Receive referrals for personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Work-Life Resources and Referrals
Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant
Save time with referrals for travel and entertainment, seeking professional services, cleaning services, home food delivery, and managing everyday tasks.

Medical Advocacy
Get help navigating insurance, obtaining doctor referrals, securing medical equipment, and planning for transitional care and discharge.

Member Portal
Access your benefits 24/7/365 through your member portal with online requests and chat options. Explore thousands of self-help tools and resources including articles, assessments, podcasts, and resource locators.



Contact: Perspectives
Call: 800-456-6327
Visit: perspectivesltd.com/login Access Code: Antioch34

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ALLONE HEALTH

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 calendar year before your plan begins paying benefits. Determined on a calendar year basis.

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

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

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

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

Preferred 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 Preferred has a wide selection of generic and brand-name medications.

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

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

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

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

Maximum annual benefit. The maximum amount the plan pays for specific services (such as dental or chiropractic) for a covered individual. Determined on a calendar year basis.

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 calendar year. Once you've reached the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the calendar 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 on which plan coverage, enrollments, and records are based. Plan years for district plans are September 1 to August 31. Accumulators for district plans (ex: deductibles, out-of-pocket maximums, and maximum annual benefits) are tied to the calendar year, not the plan year.

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

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

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

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

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid

http://myalhipp.com
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.mycohibi.com/
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
Family and Social Services Administration
http://www.in.gov/fssa/dfr/ | 800.403.0864
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
800.338.8366
Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
800.257.8563
HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
888.346.9562

KANSAS – Medicaid

https://www.kancare.ks.gov/
800.792.4884 | HIPP Phone: 800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kynect.ky.gov | 877.524.4718
Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711 | Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742

OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physician complications of the mastectomy, including lymphedema.

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

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or 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 health care 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 health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 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. 20221, 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 health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

- We can share health information about you with organ procurement organizations.
- 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 we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

HIPAA Special Enrollment Rights

Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the District's Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

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

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

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

Mundelein SD 75 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Central CUSD 301 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Mundelein SD 75

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 Mundelein SD 75 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, 470 N. Lake Street, Mundelein, IL 60060. 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. 20221
800.368.1019, **800.537.7697** (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Translated Resources

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

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

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

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

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

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

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

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

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

(Urdu)

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

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

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

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

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

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

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

Employer Name:	Mundelein School District 75
Employer State of Situs:	**Illinois**
Name of Issuer:	**BlueCross/BlueShield of Illinois**
Plan Marketing Name:	PPO 600A, PPO 750, PPO 1200, PPO HDHP 1500
Plan Year:	2025

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

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

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

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

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

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

Employer Name:	Mundelein School District 75
Employer State of Situs:	**Illinois**
Name of Issuer:	**BlueCross/BlueShield of Illinois**
Plan Marketing Name:	HMO IL. 20
Plan Year:	2025

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

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

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

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

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

_____

_____.

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notes

This benefit summary prepared by

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