Community Consolidated School District 62

January – December 2017 Benefit Summary

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

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

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

ELIGIBILITY

Benefits Overview

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

We offer a well-rounded package consisting of:

- ❑ Medical Insurance
- ❑ Dental Insurance
- ❑ Life Insurance
- ❑ Accidental Death & Dismemberment (AD&D) Insurance
- ❑ Long-Term Disability (LTD)
- ❑ Wellness Program
- ❑ Flexible Spending Account (FSA)

Who Is Eligible?

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

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

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

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when a person has health care 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.**

The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

Life Insurance and AD&D

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

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

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

WHAT'S NEW

The Who's Who of Your CCSD 62 Medical Plans

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

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

Health Care Dependent Enrollment Requirements

If you enroll dependents in the Health Care Plan, you are required to submit additional proof documentation with your enrollment. Please see proof documents listed on page 23. This year everyone enrolled in the medical plan, including spouses and children, will be required to submit their full social security number.

Your elections will be effective on January 1, 2017. You will not be permitted to change your election during the plan year unless you experience a **qualified life event.**

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

Changing your benefits during the year

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

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

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

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

Maximize Your Benefits

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

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

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

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

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

Hospital Precertification Program for the CCSD 62 Plan

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

PPO Plan Tips!

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

HMO Plan Tips!

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

BCBS Health Care Plan Administrator

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

Individual deductible and out-of-pocket pertains to the single tier. Family deductible and out-of-pocket pertains to the employee+spouse, employee+child(ren), and family tiers

	NEW HMO Illinois Non-Grandfathered	PPO Plan 500 Non-Grandfathered	
		In Network	Out-Of-Ne
Lifetime Maximum	Unlimited	Unlimited	
Deductible[1]			
Individual	N/A	$500	$700
Family	N/A	$1,500	$2,10
Coinsurance	100%	90%	70%
Out-of-pocket limit[3]			
Individual	$1,500	$1,500	$2,00
Family	$3,000	$3,000	$4,00
Covered Expenses			
Hospital			
Inpatient Services	100%	90%*	70%*
Outpatient Services	100%	90%*	70%*
Emergency Room	$75 copay Copay waived if admitted	$75 copay, then 90%*. Copay waived if adr	
Physician			
Inpatient Surgery	100%	90%*	70%*
Outpatient Surgery	100%	90%*	70%*
Primary Care Visits	$20 copay	$20 copay[2]	70%*
Specialist Visits	$40 copay	$40 copay[2]	70%*
Wellcare/Physical Exam[4]	100%	100%	70%*
Other			
X-ray and Lab	100%	90%*	70%*
Chiropractic	Copay, only if referred through PCP	90%* 30 visits per calendar year	70%* 30 visit per calenda
Therapy: Occupational, Physical or Speech	Copay only if referred through PCP, 60 combined treatments limit	90%*	70%*
Prescription Drugs			
Retail Pharmacy[2]	$10 Generic $35 Formulary Brand $60 Non-Formulary Brand	$10 Generic, $35 Formulary Brand, $60 Non-Formulary Brand	
Mail Order[2]	$20 Generic $70 Formulary Brand $120 Non-Formulary Brand	$20 Generic, $70 Formulary Brand, $120 Non-Formulary Brand	
Prescription Out-of-Pocket Limit (Single/Family)	$1,000/$2,000	$1,000/$2,000	

	PPO Plan 750 Non-Grandfathered		HDHP Plan 1500 Non-Grandfathered	
twork	In Network	Out-Of-Network	In Network	Out-Of-Network
	Unlimited		Unlimited	
	$750	$1,000	$1,500	
0	$2,100	$3,000	$3,000	
	90%	70%	90%	70%
0	$2,250	$2,500	$5,950	
0	$4,500	$5,000	$11,900	
	90%*	70%*	90%*	70%*
	90%*	70%*	90%*	70%*
mitted	$75 copay, then 90%*. Copay waived if admitted		90%*	
	90%*	70%*	90%*	70%*
	90%*	70%*	90%*	70%*
	$20 copay[2]	70%*	90%*	70%*
	$40 copay[2]	70%*	90%*	70%*
	100%	70%*	100%	70%*
	90%*	70%*	90%*	70%*
ts r year	90%* 30 visits per calendar year	70%* 30 visits per calendar year	90%* 30 visits per calendar year	70%* 30 visits per calendar year
	90%*	70%*	90%*	70%*
	$10 Generic, $35 Formulary Brand, $60 Non-Formulary Brand		90%*	
	$20 Generic, $70 Formulary Brand, $120 Non-Formulary Brand		90%*	
	$1,000/$2,000		Combined with Medical	

1 Deductibles are based on calendar year.

2 Copays are applied towards the out-of-pocket limit. Copays are not applied towards the deductible.

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.

3 The out-of-pocket limit for the PPO 500, PPO 750, and HDHP 1500 includes the deductible.

4 Applies to both adults and children, as defined by the US preventive task force.

* After deductible

** For treatment of developmental disorders

Medicare/Retirement

Medicare and Group Health Plan Coverage

When you turn 65, 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 (1.800.633.4227)**. TTY users should call **1.877.486.2048**.

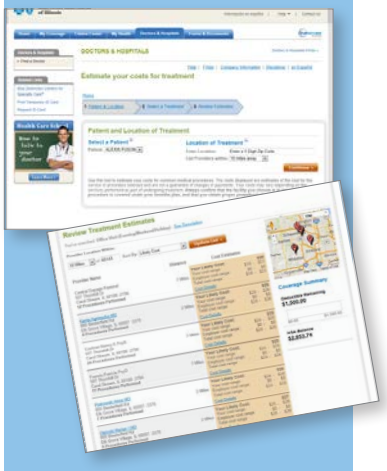
Medicare Part B benefits are optional and are available to all beneficiaries when they become entitled to Medicare Part A. Medicare Part B may be purchased by most persons age 65 and over. Although participation in Medicare Part B is optional, CCSD 62's health plans will pay as if Medicare Part B has 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. The letter states that the prescription drug program currently provided by CCSD 62 Health Care Plan meets or exceeds Medicare Part D. Medicare participants were advised that they could select the CCSD 62 prescription drug plan instead of Medicare Part D. The letter permits 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.

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	Group Health Plan	Medicare
	The employer has 20 or more employees		
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree Coverage



Provider Finder for PPO and HMO members

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

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

- ❑ Find a network primary care physician, specialist or hospital
- ❑ Filter search results by doctor, specialty, ZIP code, language and gender—even get directions from Google Maps™
- ❑ Estimate the cost of a provider's procedures, treatments and tests—and gauge out-of-pocket expenses (PPO members only)
- ❑ View patient feedback or add a provider review
- ❑ Review providers' certifications and recognitions
- ❑ View clinical quality ratings from Blue Cross as well as independent third parties
- ❑ See if the provider is accepting new patients (HMO members only)

The Provider Finder shares information that puts you in charge!

PPO MEMBERS ONLY

Doctor, Retail Clinic, Urgent Care or ER?

Blue Cross offers a quick reference guide for PPO network treatment resources.

Sometimes it's easy to know when you should go to an emergency room (ER), such as when you have severe chest pain or unstoppable bleeding. At other times, it's less clear. Where do you go when you have an ear infection, or are generally not feeling well? The emergency room is always an option, but it can be an expensive one. You have choices for receiving in-network care that work with your schedule and give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Visit **bcbsil.com** for more information or to find a provider.

Care Option	Hours	Your Relative Cost*	Description
Doctor's Office	Office hours vary	Usually lower out-of-pocket cost to you than urgent care	Your doctor's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats and minor injuries.
Retail Health Clinic	Similar to retail store hours	Usually lower out-of-pocket cost to you than urgent care	Walk-in clinics are often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems like: ear infections, athlete's foot, bronchitis and some vaccinations.
Urgent Care Provider	Generally include evenings, weekends and holidays	Usually lower cost than an ER visit	Urgent care centers can provide care when your doctor is not available and you don't have a true emergency, but need immediate care. For example, they can treat sprained ankles, fevers, and minor cuts and injuries.
Emergency Room (ER)	24 hours, seven days a week	Highest out-of-pocket cost to you	For medical emergencies, call 911 or your local emergency services first.

*The relative costs described here are for network providers. Your costs for out-of-network providers may be significantly higher.

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

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

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.

Blue Distinction: For hospitals with expertise in specialty care

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

Use the Blue Distinction Center Finder.

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

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

Blue Distinction Centers for Bariatric Surgery®

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

Blue Distinction Centers for Cardiac Care®

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

Blue Distinction Centers for Transplants®

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

Blue Distinction Centers for Complex and Rare Cancers®

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

Blue Distinction Centers for Knee and Hip Replacement℠

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

Blue Distinction Centers for Spine Surgery®

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

24/7 Nurseline for PPO Members

Around-the-Clock, Toll-Free Support

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

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

When should you call?

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

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

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

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

Special Beginnings® for PPO Members

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

- ❑ Pregnancy risk factor identification to determine the risk level of your pregnancy and appropriate range for ongoing communication/monitoring.
- ❑ Educational material including a complimentary book about having a healthy pregnancy and baby.
- ❑ Personal telephone contact with program staff to address your needs and concerns and to coordinate care with your physician.
- ❑ Assistance in managing high-risk conditions such as gestational diabetes and preeclampsia.
- ❑ Special Beginnings Online is an additional resource that provides information for each week of your pregnancy. The site can be accessed through Blue Access for Members℠.

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

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

Blue Care Connection

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

Condition Management

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

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

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

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

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

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

Lifestyle Management

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

CCEI Care Coordination and Early Intervention

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

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

Care management specialists can:

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

Case Management

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

The individualized approach features:

❑ **Episodic Case Management –** Monitors and coordinates transition to all levels of care including acute rehabilitation, skilled nursing facilities, long-term acute care, sub-acute and home settings.

❑ **Catastrophic/Complex Case Management –** Care coordination focused on members with late stage chronic conditions, serious illness or injuries such as:

- Cancer
- End stage renal disease
- High-risk pregnancies
- Infectious diseases
- Major trauma
- Premature births and birth defects
- Rare diseases
- Transplants

❑ **End of Life Care Program –** Facilitates appropriate treatment and helps members to maximize their benefits. This program addresses emotional and psychosocial issues, as well as pain and symptom management.

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

Well onTarget®

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

Well onTarget features include:

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

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

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

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

- No long-term contracts required. Membership is month to month. Monthly fees are $25 per month per member, with a one-time enrollment fee of $25
- Automatic withdrawal of monthly fee

- Online tools for locating gyms and tracking visits
- Earn 2,500 bonus Life points for joining the Fitness Program and up to 500 points with weekly visits
- Sign up for the fitness program by calling 888.762.BLUE (2583)

Blue365

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

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

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

Flexible Spending Account (FSA) – Annual Election to Participate

A flexible spending program allows you to commit a certain monthly dollar amount to a savings account set aside for **medical and childcare expenses.**

Highlights of an FSA:

- ❑ Pre-tax money (roughly a 30% savings)
- ❑ Every employer has a cap amount (maximum) see below.
- ❑ "Use it or lose it."
  - Essentially, there is an expiration date on your Flexible Savings Account. If it is not used in its entirety by December 31, 2017, then the balance is forfeited.

Healthcare:

- ❑ Individual/Family – $2,550

Dependent Care:

- ❑ Individual/Family – $5,000/year (there is no minimum for dependent care)
- ❑ Reimbursements for allowable expenses (dictated by Section 125 of the Internal Revenue Code) like deductibles, copays, vision expenses, childcare expenses.
- ❑ Claims are filed (before March 31, 2017) by the employee to WageWorks.
  - Fill out necessary forms and provide receipts, canceled checks, invoices, etc.
  - Or, use your electronic payment card program (similar to a debit card).

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

The enrollment form for your FSA plan is included in your Open Enrollment packet.

2017
FSA claims due no later than March 31, 2017, for 2016 expenses.

The District will contribute to a Health Savings Account (HSA) to go along with your High Deductible Health Plan 1500 (HDHP) option. The District will contribute $800 for single coverage and $1,500 for family coverage. If more staff elect than the pool of money committed by the Board will cover, the amounts may be reduced. Family coverage is applicable to an employee who covers someone besides themselves on the health plan. This is a great opportunity for you to invest and group your healthcare dollars and take advantage of lower premiums.

What is a Health Savings Account (HSA)?

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

Key features include:

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

FAQs

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

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

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

Q. How much money can I contribute to my HSA each year?
A. In 2017, the maximum contribution for individual coverage is $3,400 and the maximum contribution for family coverage is $6,750. HSA account holders over the age of 55 can make an additional "catch up" contribution of $1,000 per year. These limits are set by the IRS and are typically increased each calendar year for a January 1st effective date.

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

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

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

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

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

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

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

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

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

Example 1: You are a young and healthy individual with single coverage
If you are young, healthy, and are not prone to accidents, the HDHP may be the best plan option for you. In 2017, you are allowed to contribute a single maximum of $3,400 minus the $800 the District contributes, tax-free, into the HSA. If you do not experience many medical expenses, the remaining dollars will roll over to the next year and will continue to grow tax-free.

Example 2: You are close to retirement and are relatively healthy
If you are on a family plan and are over age 55, the maximum amount that you and the District can contribute to the HSA is $6,750 plus an additional $1,000 tax free. If you have limited medical expenses throughout the year, your unused dollars will accumulate and can be used to pay your Medicare premiums and healthcare expenses after your retire.

Example 3: You or a family member has a medical condition with money already saved in an HSA
An employee who has been contributing the family maximum into their HSA account would have built up a bank of $13,500 over a two year period. If your family spends an average of $1,500 a year on medical expenses (doctors visits, prescription medication, etc.) the amount in your account after two years equals $13,500-$3,000= $10,500. If someone in your family has a chronic illness beginning in the third year, you would have enough money to reach the $3,400 deductible for the year.

Optional Coverages Available: Dental

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

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

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

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

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

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

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

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

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

*There is a 24 month waiting period for orthodontics.

YOUR BENEFITS

Vision Benefits

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

In addition to the EyeMed Vision discount program, our medical policy through Blue Cross provides you and your covered family members an allowance for vision services. In order to obtain your reimbursement you need to submit your vision expense to Blue Cross along with a medical claim form. Medical claim forms can be obtained through Blue Cross's website. Our vision allowance program is as follows:

Vision Allowance Plan for PPO Members

Vision Exam	$30 per exam every 12 months
Single Vision Lenses	$30 per pair every 12 months
Bifocal Lenses	$40 per pair every 12 months
Trifocal Lenses	$50 per pair every 12 months
Lenticular Lenses	$100 per pair every 12 months
Contact Lenses	$130 per pair every 12 months
Frames	$75 per frame every 24 months

Vision Allowance Program for HMO Members

Employees enrolled in the District's HMO plan are entitled to an annual eye exam for your regular office visit copay of $10. In addition, you are entitled to $150 towards vision materials every 24 months. **Please note, you must use a EyeMed Vision Care provider to receive benefits. To locate a provider, call EyeMed Vision Care at 844.684.2254**. You can submit your itemized receipt detailing the services you have received to Blue Cross for reimbursement.

Vision Discount Programs

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

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

VSP Program

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

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

*In lieu of all other lens and frames

IMPORTANT NOTICE
EyeMed Vision Care has taken place of Davis Vision as of January 1, 2017.

YOUR NEXT STEPS

Carefully Review Your Enrollment Options

- ❑ Open enrollment dates are October 21, 2016 through October 31, 2016.
- ❑ If you are currently enrolling new dependents, proof documents are required to be submitted with your enrollment including social security numbers.
- ❑ FSA Annual Election.
- ❑ Complete your enrollment forms and turn them in to your School Secretary by 3:00 p.m. on October 31, 2016. Completed forms must be returned in the sealed HIPAA Protection envelope that is provided in your packet. No forms will be accepted unless they are in this sealed envelope.

Important Contact Information

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

Benefit	Administrator	Phone	Website/email
Medical PPO	BCBS	1.800.458.6024	www.bcbsil.com
Medical HMO	BCBS	1.800.892.2803	www.bcbsil.com
Dental PPO/Basic Life and AD&D	MetLife	1.800.942.0854	www.metlife.com/mybenefits
Flexible Spending Account (FSA)	WageWorks	1.800.346.2126	www.wageworks.com
Vision	VSP	1.800.877.7195	www.vsp.com

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

REQUIRED PROOF DOCUMENTS FOR DEPENDENT COVERAGE

Legal Marriage

- ❑ Marriage certificate.
- ❑ Civil Union documentation.

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 spouse.
- ❑ Marriage Certificate showing legal marriage between the employee and the child's parent.
- ❑ Court document showing that your spouse has custody of the child or is required to cover child.

Other Child

- ❑ 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.

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, 2016. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
COLORADO – Medicaid
http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 800.221.3943
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268
GEORGIA – Medicaid
http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) 404.656.4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.hip.in.gov | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864

IOWA – Medicaid
http://www.dhs.state.ia.us/hipp 888.346.9562
KANSAS – Medicaid
http://www.kdheks.gov/hcf 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov/dms/default.htm 800.635.2570
LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/MassHealth 800.462.1120
MINNESOTA – Medicaid
http://mn.gov/dhs/ma 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx 855.632.7633
NEVADA – Medicaid
http://dwss.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf 603.271.5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
http://www.nyhealth.gov/health_care/medicaid 800.541.2831
NORTH CAROLINA – Medicaid
http://www.ncdhhs.gov/dma 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/hipp 800.692.7462

RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov 401.462.5300
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 800.562.3022, ext. 15473
WEST VIRGINIA – Medicaid
http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx 877.598.5820, HMS Third-Party Liability
WISCONSIN – Medicaid
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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 10/31/16)

IMPORTANT NOTICES

Women's Health & Cancer Rights Act

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

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

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

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

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get an electronic or paper copy of your medical record

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

Ask us to correct your medical record

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **877.696.6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

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

IMPORTANT NOTICES

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

Address workers compensation, law enforcement, and other government requests

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

IMPORTANT NOTICES

HIPAA Special Enrollment Rights

Initial Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

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

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your plan administrator.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
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PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your 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.

[1] 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.

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)

DES PLAINES SCHOOL DISTRICT 62
WORKING TOGETHER FOR OUR CHILDREN

This benefit summary prepared by

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