Genoa-Kingston CUSD #424
Benefit Guide 2020-2021
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Dear GK Employee,

Our Annual Benefit Enrollment Period will be Monday, May 18th through Monday, June 1st, 2020. During this time, you will be able to make your benefit selections for the 2020-21 plan year. We are committed to providing a strong benefit package to help you and your family achieve and maintain optimum health and wellness.

The HR Department and Genoa-Kingston CUSD #424’s EBC management team believe the marketplace format offers the most comprehensive benefit options for employees while also managing costs. The Gallagher Marketplace Exchange (Marketplace) online store will once again be customized for Genoa-Kingston CUSD #424 and is stocked with a variety of products and programs with which you choose what you NEED. We recognize that every individual and family has different needs. Therefore the Marketplace provides a way for each employee to purchase what works best in their individual situation. If you need to change your coverages and options for next year, then you will go to the Marketplace website. The Marketplace will ask you some questions to determine your particular needs and situation. It will then recommend a personalized benefits portfolio for you. Please be assured that all of the information you share is private and in full compliance with the HIPAA privacy regulations.

The plan will also provide you with a Benefits Guide which has detailed information on new coverages and changes for 2020-21. Please review the guide to understand the new additions and plan changes and keep this for your reference throughout the year. Also, be aware that the Affordable Care Act guidelines require the Board Contribution be used exclusively for medical, dental, vision, and medical FSA plans.

In this economic and health care environment, it is essential that we all work together to manage health care. We encourage all employees to focus on wellness and to take preventive measures to increase both mental and physical well-being. We met our tier one wellness screening goals last year-let’s do it again!

As individuals, we can all become better health care consumers. As you consider your benefit elections for 2020-21, please read this Benefits Guide in its entirety to fully understand your options. We also encourage you to engage with your spouse when you log into the Gallagher Marketplace Exchange to gain further insights and answers regarding your 2020-21 benefits. It is our goal through this guide and the personal marketplace enrollment to insure that you enroll in what is the best package for your life situation. If you need assistance, Christi Volkening and Ann Pickerill are available by appointment to help walk you through the Marketplace process. They are not allowed to make selections for you, but certainly can serve as a guide.

Finally, if you do not complete the online enrollment process this year, your current year’s selections will be your default selections for this next year. However, FSA plan elections must be made online each year. Therefore, if you do not complete the online enrollment and update your FSA elections, you will not be enrolled in the FSA plan for next year.

Sincerely,

Genoa-Kingston CUSD #424
Annual Enrollment 2020—May 18th through June 1st, 2020

All Changes Go Into Effect July 1, 2020

What can I do during annual enrollment?

Enrollment is your annual opportunity to:

- Enroll yourself and any dependents in health care benefits for the first time.
- Waive health care benefit coverage for yourself or dependents.
- Add, drop, increase, or decrease your Voluntary or Dependent Life insurance. Evidence of Insurability (EOI) rules may apply.
- Add or drop any Benefit Plans.
- Elect an HSA if you are enrolled in a HDHP plan.

Remember: After Annual Enrollment ends, no changes can be made to your benefits. You may only make mid-year changes if you experience a Qualifying Life Event.

Qualifying Life Event

The following events qualify for a mid-year change in coverage:

- Marriage
- Birth or adoption of a child
- Loss of other coverage
- Change in your employment status or that of a spouse
- Divorce or legal separation
- A qualified domestic relations order or a similar court order
- Ineligibility of a dependent
- Significant change in health coverage attributable to your employment or that of your spouse

If you experience a Qualifying Life Event 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 will need to wait to change your elections during the next Annual Enrollment period. Benefits allowing a change for a qualifying life event: Medical, Dental, Vision, Critical Illness, Accident, Hospital Indemnity and Voluntary Life.
ENROLLING IS EASY

LOG IN
Visit www.EBCcooperative.com from any computer or smart device and Login with your User Name and Password.
New users must Register and answer security questions. Our case-sensitive company key is ebc.

GET STARTED
Click Start Here and follow the instructions to make your benefit choices by the deadline on the calendar. If you miss the deadline you will have to wait until the next annual enrollment period to enroll or make changes.

FIND INFORMATION
View plan details, carrier specifics and resources in the Reference Center.

MAKE YOUR ELECTIONS
Using Back and Next to navigate, review your options as you move through the enrollment process.
Select plan(s) and who you would like to cover.

ENROLL ONLINE
Enroll in your benefits from your mobile device. Visit www.EBCcooperative.com and tap your way through your elections.
Your Medical Options

BLUE CROSS AND BLUE SHIELD OF ILLINOIS

Blue Cross and Blue Shield of Illinois (BCBSIL) is the claims administrator for your district’s medical plans. Contact Blue Cross for questions regarding:

- Eligibility
- Plan benefits
- Status of claim payments

Please remember to 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.

PPO Medical Plans

To find a contracting doctor or hospital, just go to www.bcbsil.com and use the Provider Finder. For PPO Plans (with exception of PPO 3) select Participating Provider Organization (PPO) and for PPO 3 select Blue Choice Preferred PPO.

PPO Customer Service: 800.458.6024 (8:00 a.m. to 6:00 p.m., Monday through Friday).

IL Network Provider Search: 800.458.6024 (8:00 a.m. to 6:00 p.m., Monday through Friday) or www.bcbsil.com.

HMO Blue Advantage Medical Plans

When you join the HMO, you choose a contracting medical group number within your network and then a family practitioner, internist or pediatrician from your chosen medical group to serve as your primary care physician (PCP).

To find a medical group and PCP in the Blue Advantage network, go to www.bcbsil.com and use the Provider Finder.

HMO Customer Service: 800.892.2803 (8:00 a.m. to 6:00 p.m., Monday through Friday).

Your HMO Blue Advantage Plan number is located on your ID card (Blue Cross and Blue Shield of IL).

Prescription Drug Information

Prime Therapeutics is the retail and mail-order vendor (90-day supply) for enrolled members. Your medical ID card also serves as your prescription ID card. To find a participating retail pharmacy or for more information, log in to BlueAccess for Members and click on Prescription Drugs link or visit www.bcbsil.com.

Prescription Drug Inquiry Unit

Phone: 800.423.1973 (Available 24 Hrs/Day, 7 Days/Week)
Website: www.myprime.com

Home Delivery Customer Service

Through AllianceRX Walgreens Prime
Phone: 877.357.7463
Website: AllianceRxWP.com/HomeDelivery

Specialty Customer Service

Through AllianceRX Walgreens Prime
Phone: 877.627.6337
Website: AllianceRxWP.com/Specialty-Pharmacy
### HMO Medical Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>Blue Cross and Blue Shield HMO BA Option 1</th>
<th>Blue Cross and Blue Shield HMO BA Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>Blue Advantage Network In-Network</td>
<td>Blue Advantage Network In-Network</td>
</tr>
<tr>
<td><strong>HSA Qualified Plan</strong></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>Individual N/A</td>
<td>Individual N/A</td>
</tr>
<tr>
<td></td>
<td>Family (Aggregate) N/A</td>
<td>Family (Aggregate) N/A</td>
</tr>
<tr>
<td><strong>Out-of-pocket limit</strong></td>
<td>Individual $3,000</td>
<td>Individual $1,500</td>
</tr>
<tr>
<td></td>
<td>Family $6,000</td>
<td>Family $3,000</td>
</tr>
<tr>
<td><strong>Covered Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient 100% after $500 per day copay for first 3 days</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Outpatient 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Emergency Room (copays are waived if admitted) 100% after $250 copay</td>
<td>100% after $150 copay</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Surgery 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Outpatient Surgery 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td><strong>Office Visit:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Care $40</td>
<td>$20 No coverage</td>
</tr>
<tr>
<td></td>
<td>Specialist $60</td>
<td>$40 No coverage</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X-ray and Lab 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Therapy - Speech, Occupational or Physical Therapy 100% (60 combined visits)</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Mental/Nervous - Inpatient 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Mental/Nervous - Outpatient 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse - Inpatient 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse - Outpatient 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td></td>
<td>Wellcare 100%</td>
<td>100% No coverage</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Prime Therapeutics</td>
<td>Prime Therapeutics</td>
</tr>
<tr>
<td></td>
<td>Retail Pharmacy 34-day Supply</td>
<td>$15 Generic 35% Formulary Brand 50% Non-Formulary Brand</td>
</tr>
<tr>
<td></td>
<td>Mail Order 90-day Supply</td>
<td>$30 Generic 35% Formulary Brand 50% Non-Formulary Brand</td>
</tr>
<tr>
<td><strong>Prescription Out-of-Pocket Limit</strong></td>
<td>Individual $1,000</td>
<td>Individual $500</td>
</tr>
<tr>
<td></td>
<td>Family $3,000</td>
<td>Family $1,500</td>
</tr>
</tbody>
</table>

Dependent Age to 26 for all married or unmarried dependents and to age 30 for all unmarried military veteran dependents who are Illinois residents.

NOTE: This is an outline of the benefit schedules. This exhibit is no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operations of the plans.
# PPO Medical Comparison Chart

<table>
<thead>
<tr>
<th>Network</th>
<th>Blue Cross and Blue Shield PPO Option 1</th>
<th>Blue Cross and Blue Shield PPO Option 2</th>
<th>Blue Cross and Blue Shield PPO Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA Qualified Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Deductible</td>
<td>Individual: $500, $1,000</td>
<td>Individual: $1,000, $2,000</td>
<td>Individual: $1,500, $3,000</td>
</tr>
<tr>
<td></td>
<td>Family (Aggregate): $1,500, $3,000</td>
<td>Family (Aggregate): $3,000, $6,000</td>
<td>Family (Aggregate): $4,500, $9,000</td>
</tr>
<tr>
<td>Out-of-pocket limit</td>
<td>Individual: $1,000, $2,000</td>
<td>Individual: $3,000, $6,000</td>
<td>Individual: $3,400, $6,800</td>
</tr>
<tr>
<td></td>
<td>Family: $3,000, $6,000</td>
<td>Family: $9,000, $18,000</td>
<td>Family: $10,200, $20,400</td>
</tr>
</tbody>
</table>

## Covered Expenses

### Hospital

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Room (copays waived if admitted)</td>
<td>100% after $150 copay</td>
<td>100% after $150 copay</td>
<td>80% after $150 copay</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Surgery</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Office Visit:

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>$20</td>
<td>$20</td>
<td>$30</td>
<td>$30</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td>Specialist</td>
<td>$40</td>
<td>$40</td>
<td>$30</td>
<td>$30</td>
<td>$30</td>
<td>$30</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray and Lab</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Therapy - Speech, Occupational or Physical Therapy</td>
<td>90% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>60% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Nervous - Inpatient</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Mental/Nervous - Outpatient</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Substance Abuse - Inpatient</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Substance Abuse - Outpatient</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Wellcare</td>
<td>100%</td>
<td>100%</td>
<td>60%</td>
<td>60%</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th></th>
<th>Prime Therapeutics</th>
<th>Prime Therapeutics</th>
<th>Prime Therapeutics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy 34-day Supply</td>
<td>$10 Generic</td>
<td>$15 Generic</td>
<td>$8 Generic</td>
</tr>
<tr>
<td></td>
<td>$40 Formulary Brand</td>
<td>35% Formulary Brand</td>
<td>$35 Formulary Brand</td>
</tr>
<tr>
<td></td>
<td>$60 Non-Formulary Brand</td>
<td>50% Non-Formulary Brand</td>
<td>$75 Non-Formulary Brand</td>
</tr>
<tr>
<td>Mail Order 90-day Supply</td>
<td>$20 Generic</td>
<td>$30 Generic</td>
<td>$16 Generic</td>
</tr>
<tr>
<td></td>
<td>$80 Formulary Brand</td>
<td>35% Formulary Brand</td>
<td>$70 Formulary Brand</td>
</tr>
<tr>
<td></td>
<td>$120 Non-Formulary Brand</td>
<td>50% Non-Formulary Brand</td>
<td>$150 Non-Formulary Brand</td>
</tr>
</tbody>
</table>

### Prescription Out-of-Pocket Limit

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td>$1,000</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

Dependent Age to 26 for all married or unmarried dependents and to age 30 for all unmarried military veteran dependents who are Illinois residents.

NOTE: This is an outline of the benefit schedules. This exhibit is no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operations of the plans.
**PPO and HDHP Medical Comparison Chart**

<table>
<thead>
<tr>
<th>Network</th>
<th>Blue Cross and Blue Shield PPO Option 4</th>
<th>Blue Cross and Blue Shield HDHP Option 1</th>
<th>Blue Cross and Blue Shield HDHP Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>HSA Qualified Plan</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$2,800</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family (Aggregate)</td>
<td>$4,500</td>
<td>$5,600</td>
<td>$12,000</td>
</tr>
<tr>
<td>Out-of-pocket limit</td>
<td>(deductible included)</td>
<td>(deductible included)</td>
<td>(deductible included)</td>
</tr>
<tr>
<td>Individual</td>
<td>$3,400</td>
<td>$5,600</td>
<td>$6,350</td>
</tr>
<tr>
<td>Family</td>
<td>$10,200</td>
<td>$11,200</td>
<td>$12,700</td>
</tr>
</tbody>
</table>

**Covered Expenses**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Room (copays are waived if admitted)</td>
<td>80% after $150 copay</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician</th>
<th>Inpatient Surgery</th>
<th>Outpatient Surgery</th>
<th>Office Visit:</th>
<th>Primary Care</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Surgery</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>80%</td>
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<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Office Visit:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$30</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialist</td>
<td>$30</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>X-ray and Lab</th>
<th>Therapy - Speech, Occupational or Physical Therapy</th>
<th>Mental/Nervous - Inpatient</th>
<th>Mental/Nervous - Outpatient</th>
<th>Substance Abuse - Inpatient</th>
<th>Substance Abuse - Outpatient</th>
<th>Wellcare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>60%</td>
<td>80% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>80% (60 visits each)</td>
<td>60%</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Prime Therapeutics</th>
<th>Prime Therapeutics</th>
<th>Prime Therapeutics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy</td>
<td>$8 Generic</td>
<td>$35 Formulary Brand</td>
<td>$80% Generic</td>
</tr>
<tr>
<td>34-day Supply</td>
<td>$75 Non-Formulary Brand</td>
<td>80% Formulary Brand</td>
<td>$80% Formulary Brand</td>
</tr>
<tr>
<td>Mail Order</td>
<td>$16 Generic</td>
<td>$70 Formulary Brand</td>
<td>$80% Generic</td>
</tr>
<tr>
<td>90-day Supply</td>
<td>$150 Non-Formulary Brand</td>
<td>$80% Formulary Brand</td>
<td>$80% Formulary Brand</td>
</tr>
<tr>
<td>Prescription Out-of-Pocket Limit</td>
<td>Individual $1,000</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Family $3,000</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Dependent Age to 26 for all married or unmarried dependents and to age 30 for all unmarried military veteran dependents who are Illinois residents.

**NOTE:** This is an outline of the benefit schedules. This exhibit is no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operations of the plans.
**What is a High Deductible Health Plan?**

The two high deductible health plans (HDHP) your district offers are considered to be qualified HDHP and therefore you are eligible to open a Health Savings Account (HSA). An HDHP will normally have a lower monthly premium in comparison to a traditional PPO insurance plan. In order for a plan to be considered 'qualified' by the IRS it must meet the following requirements:

1. The deductible must be a minimum of $1,400 for individual and $2,800 for family.
2. No services can be paid for or covered prior to meeting the deductible (with the exception of preventive care).
3. There are no prescription drug copays. Once the deductible is met, the coinsurance applies.

**What is an HSA?**

An HSA (Health Savings Account) is a tax-free account you can use to pay for current and future medical expenses (even medical expenses during retirement). An HSA has triple tax benefits:

- The money goes in tax free
- The money grows tax free
- Your withdrawals for qualified medical expenses – including any earnings – are tax free.

**Who’s Eligible?**

You’re eligible to enroll in an HSA if:

- You enroll in either of the Marketplace’s high-deductible health plans (HDHP Option 1 or 2) and
- You are only covered by a high-deductible health plan, and you have not signed up for Medicare coverage and
- You are currently not enrolled in a Health Flexible Spending Account plan, unless it is a Limited Health FSA.

If you’re covered under your spouse’s plan and that plan is not a high deductible health plan or your spouse contributes to a Health Care FSA, then you are NOT eligible to contribute to an HSA.

**Opening your HSA Account**

As the owner of the account, you will need to complete paperwork available on our marketplace to open your HSA bank account. You can contribute to your account in any amount up to the annual IRS limits below:

- Employee Only Coverage $3,550
- Family Coverage $7,100
- Additional “Catch Up” if 55 or Older $1,000

**Pay Health Care Expenses**

Each time you have a qualified expense, you decide whether to:

- Pay out of your pocket and let your HSA grow for future eligible expenses (e.g. medical expenses during retirement)
- Use your HSA to pay for eligible medical expenses, such as your annual deductible and coinsurance. Your HSA can also help to pay for vision care, dental care, and prescription drugs. For a complete list of eligible expenses, visit www.irs.gov.

**Roll Over Your HSA Balance—This is an Account You Own**

Money you don’t spend rolls over from year-to-year, so if you switch to another medical plan or even retire, your HSA and the money in it is still yours to keep. You can choose to save it to pay for eligible health care expenses tax-free during retirement.
Preventive Care Benefit

Preventive care services are covered under all your offered medical plans at 100% (in network). Before going to your doctor, or scheduling your appointment, you should be aware of what services are considered to be “preventive”.

Services Covered at 100% Under Preventive Care Benefit include:

- Well Child Visits/Immunizations
- Routine Adult Physical Exams
- Routine Mammograms
- Routine Gynecological Exams including Pap smear
- DRE and PSA (Prostate Screening)
- Colorectal Cancer Screening
- Labs, pathology, chest x-ray, and EKG (when performed as preventive care)

*Be sure your Doctor codes the claim as “preventive.”*

**Preventive care:** Routine annual screenings to “prevent” illness or injury.

**Non-preventive care:** If diagnosed with a condition, some screenings are considered part of treatment. Be sure to talk to your doctor.

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Non-Preventive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mammogram</strong> – annually for women starting at age 40, or recommendation</td>
<td>Patient found lump in breast and doctor recommends mammogram to diagnose condition</td>
</tr>
<tr>
<td><strong>Colonoscopy</strong> – every 10 years starting at age 50, or recommendation</td>
<td>Patient has unexplained weight loss and constipation. Afraid it’s colon cancer; schedules colonoscopy</td>
</tr>
<tr>
<td><strong>Annual physical/preventive care exam</strong></td>
<td>Office visit due to fever and rash</td>
</tr>
<tr>
<td><strong>Pap smear</strong> – once annually for women who are 18 years of age or older</td>
<td>Abnormal Pap smear; returns for second exam. This second exam would be considered non-preventive.</td>
</tr>
</tbody>
</table>
**PPO Dental Benefits**

Administered by MetLife

**MetLife** is the administrator of the PPO dental benefits for you and your family.

As a member of this plan, you are free to use any dentist; however, additional discounts will be realized if you use one that participates in the MetLife PDP Plus network.

Contact MetLife at **800.942.0854** for questions regarding:

- Network providers
- Eligibility status
- Plan benefits
- Claim status and claim forms

Additionally, you can access MyBenefits at [www.metlife.com/mybenefits](http://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.

### PPO Dental Comparison Chart

<table>
<thead>
<tr>
<th>Network</th>
<th>MetLife Dental PPO Option Low</th>
<th>MetLife Dental PPO Option Mid</th>
<th>MetLife Dental PPO Option High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO Network</td>
<td>PPO Network</td>
<td>PPO Network</td>
</tr>
<tr>
<td>Deductible</td>
<td>In-Network(^1)</td>
<td>Out-of-Network(^2)</td>
<td>In-Network(^1)</td>
</tr>
<tr>
<td>Individual</td>
<td>N/A</td>
<td>$50</td>
<td>N/A</td>
</tr>
<tr>
<td>Family</td>
<td>N/A</td>
<td>$150</td>
<td>N/A</td>
</tr>
<tr>
<td>Type A: Preventive Services (cleaning and exams)</td>
<td>100(^4)</td>
<td>100(^2)</td>
<td>100(^4)</td>
</tr>
<tr>
<td>Type B: Basic Restorative (fillings, endodontics, periodontics, and oral surgery)</td>
<td>80(^4)</td>
<td>50(^2)</td>
<td>80(^4)</td>
</tr>
<tr>
<td>Type C: Major Restorative (crowns, bridges and dentures)</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>50(^4)</td>
</tr>
<tr>
<td>Type D: Orthodontia</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$750</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ortho applies to adults and child(ren)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

1 “In-Network Benefits” means benefits under this plan for covered dental services that are provided by a MetLife Participating dentist. “Out-of-Network Benefits” means benefits under this plan for covered dental services that are not provided by a MetLife Participating dentist.

2 Low and Mid Plans - Out-of-network benefits are based on MetLife negotiated fees.

3 High Plan - Out-of-network benefits are based on reasonable and customary charges.

4 Refers to the fees that In-Network dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums.

5 Applies to Type B and C services only.

**NOTE:** This is an outline of the benefit schedules. This exhibit is no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operations of the plans.
**Vision Insurance**

Insured by EyeMed

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.

To find an EyeMed in-network provider, log on to [www.eyemed.com](http://www.eyemed.com), click on “Find a Provider”, enter your location information and select the “Insight” network.

**Vision Comparison Chart**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>Insight Network</td>
<td>Insight Network</td>
<td>Insight Network</td>
</tr>
<tr>
<td><strong>Vision Exam</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam with Dilation</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Retinal Imaging Benefit</td>
<td>Up to $39</td>
<td>Up to $39</td>
<td>Up to $39</td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow Up</td>
<td>Up to $55</td>
<td>Up to $55</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow Up</td>
<td>10% off retail</td>
<td>10% off retail</td>
<td>10% off retail</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any available frame at provider location</td>
<td>$0 copay; $130 allowance (20% off balance over $130)</td>
<td>$0 copay; $150 allowance (20% off balance over $150)</td>
<td>$0 copay; $175 allowance (20% off balance over $175)</td>
</tr>
<tr>
<td>Standard Plastic Lens</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single, Bifocal, Trifocal, &amp; Lenticular Vision</td>
<td>$20 Copay</td>
<td>$20 Copay</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Standard Progressive</td>
<td>$85</td>
<td>$85</td>
<td>$65</td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Treatment &amp; Tint</td>
<td>$15</td>
<td>$15</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Standard Polycarbonate - Adults</td>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Standard Polycarbonate - Child</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Standard Ant-Reflective Coating</td>
<td>$45</td>
<td>$45</td>
<td>$45</td>
</tr>
<tr>
<td>Other Add-Ons</td>
<td>20% off retail</td>
<td>20% off retail</td>
<td>20% off retail</td>
</tr>
<tr>
<td><strong>Contact Lens</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional Lens</td>
<td>$0 copay; $130 allowance (15% off balance over $130)</td>
<td>$0 copay; $150 allowance (15% off balance over $150)</td>
<td>$0 copay; $150 allowance (15% off balance over $150)</td>
</tr>
<tr>
<td>Disposable Lens</td>
<td>$0 Copay; $130 allowance</td>
<td>$0 Copay; $150 allowance</td>
<td>$0 Copay; $150 allowance</td>
</tr>
<tr>
<td><strong>Frequency of Service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>12 Months</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Lenses or Contact Lenses</td>
<td>12 Months</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Frame</td>
<td>24 Months</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
</tbody>
</table>

NOTE: This is an outline of the benefit schedules. This exhibit is no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operations of the plans.
Voluntary Life Insurance
Insured by Reliance Standard Life Insurance Co.

Eligibility

Employees: Each Active, Full-time employee working 20 or more hours per week, except any person working on a temporary or seasonal basis.

Dependents: You or your spouse must be insured in order for Dependent children to be covered.

Dependents are:
• Your legal spouse under age 70.
• Your unmarried financially dependent children* age 14 days to 20 years (to 26 years if full-time student).
  *natural and adopted children upon finalization of adoption; stepchildren and foster children living with you.
  Upper age limits do not apply to handicapped children.

Benefit Amount

Employee and Spouse:
- A minimum of $10,000 to a maximum of $500,000 (in $10,000 increments) for yourself and/or your spouse.

The benefit amounts chosen need not be the same.

Eligible Dependent Child(ren):
- Age 14 days to 6 months: $1,000
- Age 6 months to 20 years of age (26, if full-time student): choice of $5,000, $10,000; $15,000 or $20,000

Choose one benefit amount for all eligible children in family.

Guarantee Issue (Initial Eligibility Period Only)

Employee:
- Under age 60: $150,000
- Age 60 but under age 70: $10,000
- Age 70 or older: none

Spouse:
- Under age 60: $50,000
- Age 60 or older: none

Guarantee Issue is subject to underwriting rules and is not available in all circumstances.

Benefit Reduction Due to Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Original Benefit Reduced to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>60%</td>
</tr>
<tr>
<td>80</td>
<td>35%</td>
</tr>
<tr>
<td>85</td>
<td>27.5%</td>
</tr>
<tr>
<td>90</td>
<td>20%</td>
</tr>
<tr>
<td>95</td>
<td>7.5%</td>
</tr>
<tr>
<td>100</td>
<td>5%</td>
</tr>
</tbody>
</table>

Features

- Conversion Privilege
- Accelerated Death Benefit (expressed as Living Benefit Rider in some states and Imminent Death Benefit in PA)
- Portability
- Waiver of Premium

Exclusions

Death by suicide is not covered during the first two years an insured’s insurance is in force. Insurance coverage is incontestable after it has been in force two years during the insured’s lifetime, except for non-payment of premium.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the insurance plan. It is not a certificate of insurance or evidence of coverage.

Scheduled Benefit:

Each eligible employee may elect for himself and/or his eligible spouse an amount of insurance:
For employees age 75 and older, benefit amounts are reduced according to the age-based reduction chart shown in the Reference Center in www.benefitsolver.com.
When selecting an amount of insurance, you must select a pre-age 75 benefit amount.

Please Read this Important Information:

- You may not have coverage as both an employee and as a dependent.
- Only one insured spouse may cover the eligible dependent children.
- Neither you nor your spouse may hold more than a total of $500,000 of group term life insurance with Reliance Standard under the master Group Policy. Insurance over that amount will be void and the premium refunded.
Reliance Standard Worksite Products

Medical insurance offsets most of the treatment costs for injuries and illnesses; however, there are out of pocket costs that can occur, including meeting a high deductible, that can make a serious dent in a family’s savings. Critical Illness, Voluntary Accident, and Hospital Indemnity Insurance through Reliance Standard are three lines of coverage that can help protect you and your family.

Accident Insurance

Accident insurance pays a lump-sum benefit for injuries resulting from a covered accident—up to and including death. These benefits are paid directly to you or your designee, to use however you wish. The benefit schedule specifies payment amounts for events like hospitalizations, Emergency Room treatments, surgery, coma, paralysis, major diagnostic test, physical therapy, fractures, burns, etc. The plan also has a wellness benefit, which pays you a lump sum for each annual wellness screening.

You cannot be turned down for this insurance if you are an eligible employee—coverage is guaranteed.

Critical Illness Insurance

If you have to be treated for a critical illness like cancer, stroke or heart attack, critical illness insurance can help cover expenses while you’re potentially facing a loss of income. You can purchase coverage for yourself, your spouse and your children. Your spouse is entitled to the same level of benefits as you, and your dependent child may receive a percentage of your benefit coverage amount up to $7,500.

There are three categories of critical illnesses that are covered, each with a 200% lifetime max:

- Cancer
- Cardiovascular
- Other

Please note:

- This plan includes a pre-existing condition limitation.
- If you do not enroll during the initial eligibility period (as a new hire or during the 2018 special open enrollment) you will need to go through medical underwriting.

Hospital Indemnity Insurance

The average cost of a one-day hospital admission is over $2,000. Hospital indemnity insurance helps to protect you from possible out of pocket costs by paying a fixed, lump-sum daily benefit to help cover expenses resulting from a covered hospitalization. The benefit is paid directly to you, and the cost of the insurance is also eligible for reimbursement through your HSA, if applicable. Different benefit amounts are paid out for events such as hospital admission, and room and board. The plan also has a wellness benefit, which pays you a lump sum for each annual wellness screening.

You cannot be turned down for this insurance if you are an eligible employee—coverage is guaranteed.
Identity Theft Insurance

Insured by ID Watchdog

You may already be a victim of identity theft without knowing it. Victims may discover the problem when they are denied credit or employment, are contacted by the police, or receive unknown bills. ID Watchdog offers different levels of identity theft protection to fit your needs, guaranteeing 100% resolution services should you become a victim.

Some of the services include:

- Instant Identity Monitoring
- Internet Monitoring
- Enhanced Non-Credit Loan Monitoring
- Fraud Alert Assistance and Reminders
- Credit Monitoring
- Solicitation Reduction

For more information visit [www.idwatchdog.com](http://www.idwatchdog.com) or call 866.513.1518.
Flexible Spending Account (FSA)

Discovery Benefits

An FSA allows you to set aside a portion of your salary, before taxes, to pay for qualified medical or dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket. Follow these three steps and start making plans for that extra money you’ll bring home:

1.) Plan—how much money you want to set aside

2.) Spend— on dependent care and out-of-pocket medical expenses

3.) Collect—the money you’ve set aside

- Health FSA—set aside money to pay expenses not covered by your medical insurance. There are two types of accounts:
  - If you have traditional medical insurance, you’ll use a regular Health FSA for things like coinsurance, prescriptions and vision and dental expenses.
  - If you have a high deductible health plan (HDHP) along with a health savings account (HSA), you can use a Limited Health FSA to pay for dental, vision and medical preventive care until your annual deductible is met.

- Dependent Care Account (DCA) - set aside money for dependent care for children up to age 13, a disabled dependent of any age or a disabled spouse. To be eligible for this type of account, both you and your spouse (if applicable) must work, be looking for work, or be full-time students.

The current IRS limits for FSA contributions are as follows:

- Health Care FSA → $2,750
- Dependent Care FSA → $5,000

Note: In some cases, you will be required to submit your BCBS Explanation of Benefits (EOB) as substantiation for your expense. If you receive a receipt from your provider for a copay amount, make sure the receipt says “copay”. If not, ask your provider to write “copay” on your receipt before leaving the office.

Vague or missing information causes your reimbursements to be delayed or become ineligible. You should always keep your receipts for documentation. If audited by the IRS at a later time, you will be required to produce documentation for all medical FSA expenses.

Please note that if you contribute to a Health Savings Account (HSA) you can only have a Limited Scope FSA (dental and vision expenses only.)

For more information, call Discovery Benefits at 866.451.3399 or visit www.DiscoveryBenefits.com.
Basic Life Insurance and AD&D

Insured by Reliance Standard

As part of your benefit package, the district enrolls you in Basic Life and Accidental Death and Dismemberment (AD&D). In the unfortunate event of your death, your beneficiary will receive your life insurance benefit. Make sure you keep your beneficiary form up-to-date in benefitsolver.com, for all lines of coverage which have a death benefit.

This benefit is completely district paid, at no cost to you. For more information, contact your Benefits Office.
**EAP**

Your district offers you an Employee Assistance Program (EAP) through ACI Specialty Benefits. From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

The benefits are free of charge and include:

- Unlimited Telephonic Clinical Assessment and referral
- Up to 3 sessions of Professional Assessment for Employees and Family Members
- Unlimited Child Care and Elder Care Referrals
- Legal consultation for unlimited number of issues per year
- Financial Consultation for unlimited number of issues per year
- Unlimited community-based resource referrals

For more information, contact your Benefits Office.

ACI Specialty: Telephone—**855.RSL-HELP (855.775.4357)**  Website: [http://rsli.acieap.com](http://rsli.acieap.com)

**Teladoc**

As a member of the EBC (Educational Benefit Cooperative), you and your eligible dependents have access to telemedicine 24/7/365 through Teladoc. For employees enrolled in a High Deductible Health Plan, you will have a $45 charge; however, for members enrolled in PPO or HMO there is no charge at all. Teladoc does not replace your primary care physician. It is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many of your medical issues.

Teladoc doctors are U.S. board certified, licensed in your state and average 15 years of practice experience. With your consent, Teladoc will provide information about your consult to your primary care physician.

Some of the conditions treated by Teladoc include:

- Sinus problems
- Bronchitis
- Allergies
- Cold and Flu symptoms
- Respiratory infection
- Ear infection

To learn more about Teladoc visit [www.teladoc.com](http://www.teladoc.com) or call **1.800.Teladoc (835.2362)**.

**Navigate Wellbeing Solutions**

**Coming July 2020**

Your physical, financial, and emotional wellbeing are extremely important. In order to support, and offer you sources all in one place, the EBC has partnered with Navigate Wellbeing Solutions to provide a unified wellbeing engagement platform. Through the secure site, you will have access to group challenges, e-learning opportunities, health resources including workout videos and healthy recipes, and information on free programs the district provides, even if you are not enrolled in benefits.
Benefits Value Advisor

(PPO and HDHP plans only)

Call a Benefits Value Advisor to help you compare cost on your next procedure!

The BVA is a personal concierge service that will help you choose doctors, providers, and facilities while helping you to maximize your benefits.

A Benefits Value Advisor can:

• Help you compare costs at different providers near you
• Help you schedule your appointment
• Tell you about online educational tools
• Explain your BCBS Explanation of Benefits and claims questions

Call 800.458.6024 or the number on the back of your BCBS ID card before your next procedure!

BCBS Member Rewards

(PPO and HDHP plans only)

Earn **CASH REWARDS** when you choose a low-cost provider for certain services and procedures. The program uses the Provider Finder® —a database of independently contracted providers, which can help members:

• Compare costs and quality for numerous procedures
• Estimate out-of-pocket costs
• Assist in making treatment decisions with their doctors.

Using this resource to shop for services based on price and location, as well as quality metrics, allows you to earn cash for selecting lower-cost care. The result puts extra cash in your pocket.

Please note, all rewards are taxable to the member.
Blue Access for Members

To access the many resources available to Blue Cross and Blue Shield members, register to participate in Blue Access for Members at www.bcbsil.com. To register, click on “Log In” tab located on the right side of the homepage, and click on “Register Now” for new users. Be sure to have your BCBS ID card handy.

Blue Access is available 24 hours a day, 7 days a week, 365 days a year.

Blue Access Features

- Claim Status
- View your personal information
- Locate a provider
- Access to health and wellness information
- Compare hospitals and physicians
- Receive email alerts
- Print a temporary ID card or order a replacement card
- Cost Estimator
- View and print Explanation of Benefits (EOB)

Blue Cross Blue Shield Global Core

Blue Cross Blue Shield Global Core provides members with access to medical assistance service, doctors and hospitals in nearly 200 countries and territories around the world.

To take advantage of the Blue Cross Blue Shield Global Core program contact BCBSIL for coverage details. The Blue Cross Blue Shield Global Core Service Center is available 24 hours a day, seven days a week toll-free at 800.810.BLUE (2583) or by calling collect at 804.673.1177.

Wellbeing Management

The Wellbeing Management program is designed to help you take charge of your health and provide you with the tools to better manage your benefits. Members have access to a variety of resources through Blue Cross and Blue Shield’s secure website and Blue Access for Members.

24/7 Nurseline—Around-the-clock, toll-free support (PPO and HDHP Members Only)

The 24/7 Nurseline can help you figure out if you should call your doctor, go to the ER or treat the problem yourself.

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, 7 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. For medical emergencies, call 911 or your local emergency service first.

BLUE365 Discount Programs

FITNESS PROGRAM

Fitness Program is a four-tier membership program that gives you unlimited access to a nationwide network of fitness centers. With more than 11,000 participating 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. To search for a gym, please log in to Blue Access for Members or call 888.762.2583.

Other program perks are:

- No long-term contract required. Membership is month to month. Onetime enrollment fee of $19.
- Enroll in a tier that fits your budget and preferences.
  - Base: $19/ month
  - Core: $29/month
  - Power: $39/month
  - Elite: $99/month
- Automatic withdrawal of monthly fee.
- Online tools for locating gyms and tracking visits.
- Earn bonus Life Points for joining the Fitness Program. Rack up more points with weekly visits.
BCBS Member Resources

DIABETES PROGRAM

Complimentary Glucose Meters: BCBSIL offers glucose meters to members with diabetes at no additional charge to help you manage your condition.

CONTOUR NEXT Blood Glucose Monitoring Systems

To order a CONTOUR NEXT meter to be shipped directly to you, call 800.401.8440. Be sure to identify yourself as a BCBSIL member and mention ID code “BDC-BIL”. Or you can visit http://ContourNextFreeMeter.com

HEARING AID PROGRAM

TruHearing: Blue Cross and Blue Shield of Illinois (BCBSIL) has arranged a discount program through TruHearing that offers digital hearing aids at a reduced price. This program is available to BCBSIL health plan members, as well as parents and grandparents who are not enrolled in a BCBSIL plan.

Contact: To learn more about TruHearing or to find a location, visit their website at www.truhearing.com or call 800.687.4796 and identify yourself as a BCBSIL member.

VISION PROGRAM

Save on eyeglasses, as well as contact lenses, laser vision correction services, examinations and accessories. For a list of providers near you, go to www.eyemed.com, click Find a Provider, then choose the “Select Network” for HMO members and “Advantage Network” for PPO Members. HMO members receive their vision exam benefit via EyeMed. PPO and HMO members can receive discounts through Davis Vision and EyeMed Providers.

HMO EyeMed (Select Network): 877.393.8844
PPO EyeMed (Advantage Network): 866.273.0813
Davis Vision: 888.897.9350

WEIGHT MANAGEMENT PROGRAM

Jenny Craig, Seattle Sutton, Nutrisystem

Members may reach their weight loss goals with savings from leading programs. They may save on health meals, membership fees (where applicable), nutritional products and services.

For more discount programs, sign up on the Blue365 website at blue365deals.com/BCBSIL and start receiving weekly “Featured Deals”

BCBS Well onTargetSM

A Dynamic Wellness Program

Wellness is more than diet and fitness. It involves making healthy choices that enrich your mind, body and spirit. Well onTarget is designed to give you the tools and support you need to make these choices, while rewarding you for your hard work.

Well onTarget Features:

Well onTarget Member Wellness Portal

The heart of Well on Target is the member portal. It uses the latest technology to offer you an enhanced online experience. This engaging portal links you to a suite of innovative programs and tools.

- onmytime self-directed courses on topics such as healthy eating, stress, weight management and fitness
- Health and wellness content
- Tools and trackers, such as a food diary
- Blue Points program

Blue Points

With the Blue Points program, you will be able to earn points by regularly participating in a range of healthy activities. You can then redeem your points for popular health and wellness merchandise and services.

Blue Points offers you many features:

- Instant recognition of points. Real-time granting of points gives you instant notice of your healthy efforts.
- Easily manage your points. The interactive portal makes it easy to understand how many points are available to be earned. You can also track the total number of points earned year-to-date. All of your point data will be displayed on one screen.
- Get more Blue Points. The Blue Points program gives you the option to supplement your Blue Points balance using a credit card to redeem your points for a larger reward.
- Expanded selection of rewards. Redeem your hard-earned points in an expanded online Shopping Mall.
Glossary of Health Insurance and Medical Terms

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

**Brand Name Drugs:** Medications are marketed under a trademark-protected name and are often available from only one manufacture.

**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%.

**Copay:** A fixed amount you pay for a covered healthcare service, usually at the time of service.

**Deductible:** The amount of medical or dental expenses you must pay each year before your plan begins paying benefits.

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

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

**Formulary Brand Name Drugs:** A list of prescribed medications that are preferred by your plan because they are safe, effective alternative to other generics or brands that may be more expensive. The formulary has a wide selection of generic and brand-name medications.

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

**Hospital Outpatient Care:** Care in a hospital that doesn’t require an overnight stay.

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

**Maximum annual benefit:** The maximum amount the plan pays for specific services (such as dental or chiropractic) for a covered individual, each plan year.

**Medically necessary:** Services and supplies that the insurance company determines to be consistent with generally accepted practices for the diagnosis of an illness of injury, or the medical care of a diagnosed illness or injury. Only medically necessary services and supplies are covered by the plan.

**Out-of-Network Provider:** The facilities, providers and suppliers who don’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see an out-of-network provider.

**Out-of-pocket Limit:** Is the most you have to pay for covered medical expenses in a year. Once you’ve reached the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. This limit never includes your premium, balance-billed charges or charges the plan doesn’t cover.

**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.

**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 final 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.
**Section 1557**

The Nondiscrimination in Health Programs and Activities Final Rule implements Section 1557 of the Affordable Care Act, which prohibits discrimination in the administration of health insurance based on race, color, national origin, age, gender (gender identity) or disability.

Genoa-Kingston CUSD #424 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCION (Spanish): si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica.
Llame al **815.784.6222 ext. 1730**

UWAGA (Polish): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer **815.784.6222 ext. 1730**

### Carrier Contact Information

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Phone Number</th>
<th>Website</th>
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<tbody>
<tr>
<td>BCBS of IL</td>
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<tr>
<td>BCBS PPO</td>
<td>800.458.6024</td>
<td><a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>BCBS HMO</td>
<td>800.892.2803</td>
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<tr>
<td>Prime Therapeutics</td>
<td>800.423.1973</td>
<td></td>
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<tr>
<td>Discovery Benefits (FSA and HSA)</td>
<td>866.451.3399</td>
<td><a href="http://www.discoverybenefits.com">www.discoverybenefits.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>855.RSL-HELP (855.775.4357)</td>
<td><a href="http://rsli.acieap.com">http://rsli.acieap.com</a></td>
</tr>
<tr>
<td>EyeMed</td>
<td>866.939.3633</td>
<td><a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a></td>
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<tr>
<td>ID Watchdog</td>
<td>866.513.1518</td>
<td><a href="http://www.idwatchdog.com">www.idwatchdog.com</a></td>
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<tr>
<td>MetLife Dental</td>
<td>800.942.0854</td>
<td><a href="http://www.metlife.com">www.metlife.com</a></td>
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<tr>
<td>Teladoc</td>
<td>800.835.2362</td>
<td><a href="http://www.teladoc.com">www.teladoc.com</a></td>
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