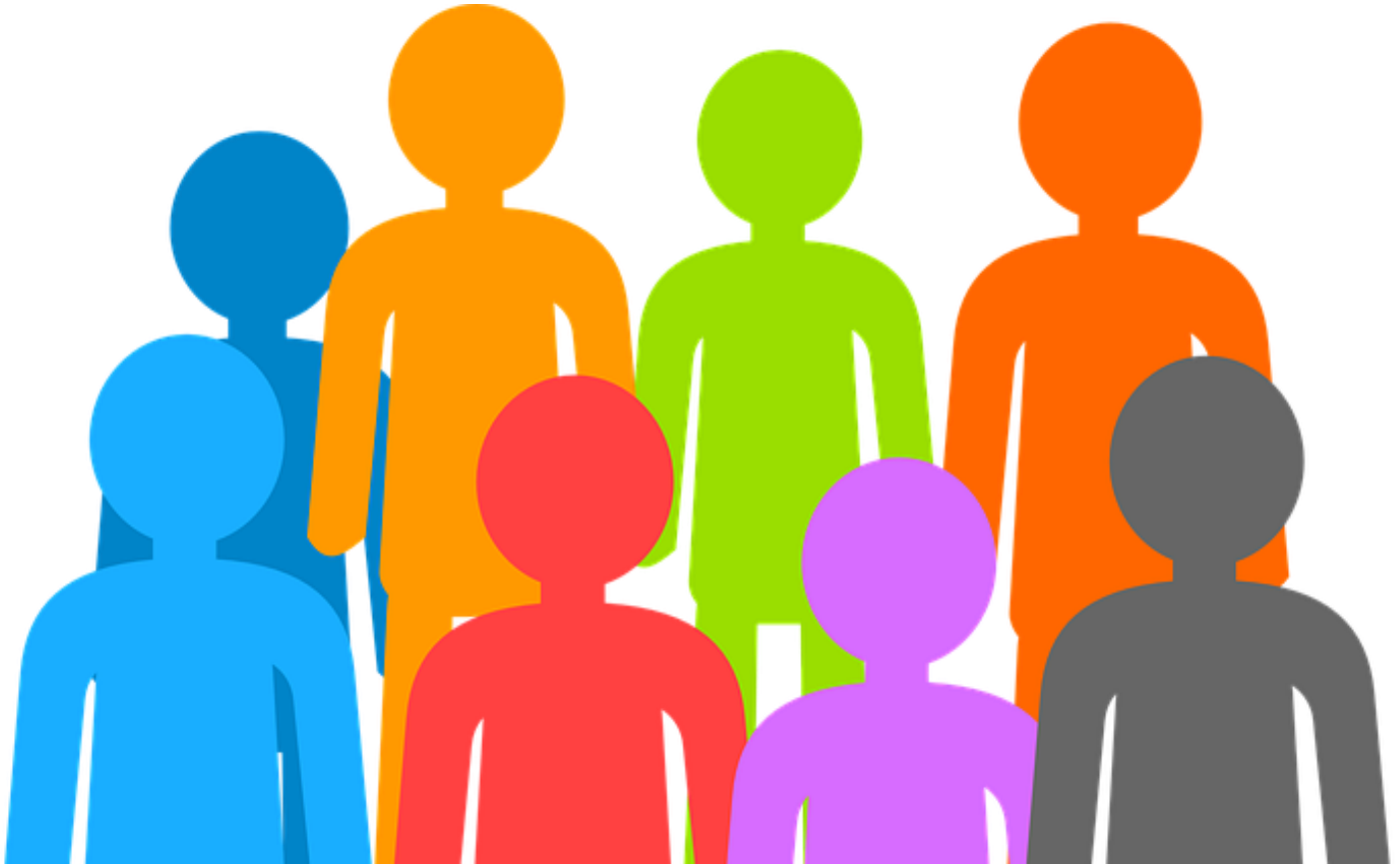
Naperville 203
Community Unit School District



Your Health Matters

2023 BENEFITS GUIDE

Quick Reference Guide to Employee Benefits

Accessing Employee Benefit Information Employee Benefits Guide, Forms, Enrollment Information

Go to D203 Website Home Page –> Select Departments –> Human Resources –> Health & Well-Being 203

Accessing YOUR Employee Benefits Account

Go to Staff Logins page –> click on Naperville 203 Employee Benefits icon (Company Key: D203)

Go to **employeebenefits.naperville203.org** (Company Key: D203)

Experiencing an IRS Qualifying Life Event Marriage/Divorce, Baby/Adoption, Loss of Insurance Coverage, etc.

Employees have 31 days from the date of a Qualifying Life Event to make changes to their employee benefits. In order to make new elections due to a Qualifying Life Event, the employee must make the change to their Employee Benefits Account and submit required documentation to the D203 Benefits Specialist within 31 days of the Qualifying Life Event date.

Considering a Leave of Absence

Contact your Human Resources Generalist and Employee Benefits Specialist

Changing Personal Information Name, Address, Phone, Emergency Contact

Name: Contact your Human Resources Generalist

Address, Phone, Emergency Contact: Go to InsideNaperville203 on Staff Logins page –> Select Departments –> Human Resources –> Click on the Address Change Form link on the left side of page

Annual Benefits Enrollment

Starts mid-October with a January 1 effective date

Outcomes Based Wellness Program

Screenings start mid-September; participation required to receive with-Wellness premium

Benefits Plan Carriers

Medical (Platinum PPO and Gold PPO HDHP)	BlueCross BlueShield of Illinois
Prescription Drugs	Prime Therapeutics
Dental	Delta Dental
Vision	Humana Vision
Health Care Flexible Spending Account	PayFlex Systems
Dependent Care Flexible Spending Account	PayFlex Systems
Health Savings Account	Lively
Employee Assistance Program	Northwestern Medicine at Central DuPage Hospital
Telehealth Medical	Teladoc
Telehealth Behavioral Health	Teladoc
Basic Life Insurance	Reliance Standard Life Insurance
Voluntary Life, Critical Illness, Accident Insurance	Reliance Standard Life Insurance

Contact information for carriers is available on the last page of this Employee Benefits Guide, on the district website and on your insurance cards.

Note: Please see the District 203 website for the most up-to-date information.

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Introduction

Naperville Community Unit School District 203 offers a comprehensive suite of benefits to help support the physical and financial health of you and your family. These benefits help you pay for health care and provide financial protection for you and your family.

Read this guide carefully to fully understand your benefits and how they work in order to make the best decision for you and your family. Being thoughtful about your benefits is a good thing – it's the first step to ensuring your family has the protection needed to be healthy throughout the year.

To keep the plan rich and overall costs down, the Insurance Committee works diligently to continually evaluate existing plans and review cost containment strategies. Effective January 1, 2023, there is an increase in premium for the Platinum PPO – Broad Network only, with no plan design changes.

This guide provides **highlights** of your benefits programs. Keep this guide with your other important papers so you can refer to it as needed. For a complete description of your benefits please refer to your benefit plan certificates, located on the district website under Health & WellBeing 203.

Naperville 203
Community Unit School District

Enrollment

New Employee Enrollment As a newly hired employee of Naperville Community Unit School District 203, you are eligible to make an election of benefits within 31 days of your effective date.

Existing Employee Enrollment **Annual Benefits Enrollment starts mid-October to make elections for benefits effective January 1 to December 31.** If you wish to change benefits outside of the Annual Benefits Enrollment period, **you may only do so within 31 days of an IRS qualifying life event**, such as:

- Employee's legal marital status changes, such as marriage, divorce, separation or the death of a spouse
- A change in the number of dependents, such as birth, death or adoption
- Changes in employment status of the employee, spouse or dependents, **which affects benefit eligibility status**. This includes beginning or ending employment, new or different work hours, a change due to a strike, a change from full-time to part-time status or vice versa or beginning or ending an unpaid leave of absence
- A dependent becoming eligible or ineligible for coverage due to age, obtaining other group coverage or any similar circumstance

Benefit changes due to a qualifying life event must satisfy a consistency rule. That is, an election of benefits or change in coverage must be on account of, and correspond with, the change in status that affects eligibility for coverage under the medical and dental plan.

Voluntarily terminating existing benefits does not qualify as an IRS qualifying life event. You have the right to terminate your benefits with Naperville CUSD 203 during the Annual Benefits Enrollment period. The last effective date of coverage will be December 31, 2022; you may not rejoin the plan until the next Annual Benefits Enrollment period unless you experience an IRS qualifying life event.

It is your responsibility to notify your Employee Benefits Specialist and take action within 31 days of an IRS qualifying life event date. Any misrepresentations, inaccurate information, or failure to provide information could result in the loss of coverage. If you cover an individual who is not eligible for benefits, you will be required to reimburse the plan for any expenses incurred as a result and further disciplinary actions may be taken.

Enrollment in Naperville CUSD 203's **family** health care plan requires proof of dependent eligibility. Eligible dependents are spouses, civil union partners, and children (biological, adopted and those for whom you have legal guardianship and accompanying documentation) under age 26. You will be required to provide the following documents (as applicable) to the Employee Benefits Specialist:

- A copy of your Marriage or Civil Union Certificate OR a copy of your most recent joint Federal Tax Return
- A copy of the Birth Certificate for each dependent to be covered under the plan, excluding your spouse, OR Adoption Certificate or Court Order
- Spousal/Civil Union Partner Affidavit

Divorced or legally separated spouses are ineligible for coverage as of the day of the divorce or legal separation. Dependent children are eligible for coverage through the month they turn age 26. **It is essential to notify your Benefits Specialist of a change in eligibility within a timely manner to ensure your dependent's right to COBRA Continuation**.

Medical/Prescription Drug Plan

Medical insurance is one of your most important benefits. When you enroll in one of the BlueCross BlueShield of Illinois medical plans offered by Naperville Community Unit School District 203 you have peace of mind knowing that you can pay for medical services if you need them for you or your family. Prime Therapeutics (BlueCross BlueShield's prescription partner) administers the prescription drug plan, providing you a single ID card for medical and prescription drug coverage. Please note that CVS/Target is not an option as a prescription drug retailer.

District 203 offers four medical/prescription plans from BlueCross BlueShield of Illinois from which to choose:

Platinum PPO This traditional PPO plan features a low deductible, co-insurance, and copays for office visits and prescriptions. This plan is grandfathered so it is not required to comply with all of the features of the Affordable Care Act including covering preventive care without cost sharing and limiting the amount paid out-of-pocket. As such, with the Platinum PPO plan, the first $500 of preventive care per individual per calendar year is covered at 100% with no deductible or copay. The remainder is subject to 80% after deductible, and there is no limit to medical and prescription copay accumulation.

Platinum PPO Limited Network This plan combines the conventional deductible, co-insurance, and copay structure of a traditional PPO plan with the claims savings that come from using a narrow network. This plan utilizes the Blue Choice Select network which is a smaller network of providers but features greater average discounts and lower negotiated in-network fees. To fully take advantage of this plan, it is important to confirm in-network status with your provider every time services are rendered. To find a provider in BlueCross BlueShield's Blue Choice Select network, visit BCBSIL.com or call 1.800.458.6024. In addition, this plan features a lower premium than the Platinum PPO and is non-grandfathered so it complies with the Affordable Care Act's requirements of In-Network preventive care covered 100% with the deductible waived and annual maximum out-of-pocket limits.

Gold PPO HDHP This high deductible health plan features the same PPO network as the Platinum PPO plan with 100% coverage in-network after the deductible is satisfied. This plan is non-grandfathered and complies with the Affordable Care Act's requirements of in-network preventive care covered at 100% with the deductible waived and annual maximum out-of-pocket limits. This plan includes a Health Savings Account with employer contributions, described further on page 18. In addition, this plan has a lower annual premium than the Platinum PPO plan.

Gold PPO HDHP Limited Network This plan combines the traditional HDHP structure with the claims savings that come from using a narrow network. This plan, like the Platinum PPO Limited Network plan, utilizes the Blue Choice Select network. In addition, this plan features a lower premium than all other offered plans, and is non-grandfathered so it complies with the Affordable Care Act's requirements of in-network preventive care covered 100% with the deductible waived and annual maximum out-of-pocket limits.

The charts on pages 7 - 10 highlight features of each of the plans listed above. See Appendix A for a helpful flow chart if you are unsure of which plan is best for you. Please see the benefit plan certificate (available on the District 203 website) for full coverage information. For further information on any of the medical/prescription plans, or to find an in-network provider, visit BCBSIL.com or call 1.800.458.6024.

Limited Network To find out if a doctor is in the Limited Network, use the Provider Finder tool at BCBSIL.com. Search **Blue Choice Select PPO (BCS)** network. **Important: Do not log into your current account if you are trying to search for a doctor in the Limited Network.** See Appendix B for full instructions.

BlueCross BlueShield of Illinois' Benefits Value Advisor When you enroll in any one of the District 203 Health Plans, you gain access to BCBSIL's Benefits Value Advisor (BVA), a customer service program to help you improve your quality of care and achieve cost savings.

- Find and compare In-Network providers based on quality, patient reviews and cost
- Compare treatment cost estimates among facilities to access savings
- Obtain preauthorization, schedule appointments and connect to clinical programs
- Review benefits, claims and coverage guidelines

BlueCross BlueShield of Illinois' Utilization Management Programs

Utilization Review Program Utilization Review assists you in determining the course of treatment that will maximize your benefits. The program requires a review of inpatient hospital, skilled nursing facility, coordinated home care program, and private duty nursing services before they are rendered. Members are required to contact the Utilization Review department at the toll-free telephone number identified on your ID card one business day prior to elective admission or within two business days after an emergency or maternity admission. Failure to receive Preauthorization will result in a $200 reduction of benefits.

Mental Health Unit The Mental Health Unit assists in the administration of Mental Illness and Substance Abuse Rehabilitation Treatment benefits. The Mental Health Unit requires a review of inpatient hospital, emergency mental illness or substance abuse admission, partial hospitalization and outpatient services before they are rendered. Members are required to contact the Mental Health Unit at 1.800.851.7498 at least one business day prior to non-emergency inpatient hospital admission and outpatient services or within two business days after an emergency admission or partial hospitalization treatment. Failure to receive preauthorization will result in a $200 reduction of benefits.

Prescription Prior Authorization Certain medications and drug classes require authorization from Prime Therapeutics for benefits to be provided. To receive prior authorization, your physician must send a letter to Prime Therapeutics explaining the reason for the prescription; you and your physician will be notified of the determination. To review the formulary list of medications and drug classes which require prior authorization, contact your pharmacy or call the customer service toll-free number on your identification card. *Platinum PPO Plans only*

Step Therapy Certain medications and drug classes require documented treatment with a generic or brand therapeutic alternative medication prior to coverage of brand name medication. If your physician prescribes such a medication, they must complete a questionnaire regarding your previous treatment; you and your physician will be notified of the determination. To review the formulary list of medications and drug classes which require prior authorization, contact your Pharmacy or call the Customer Service toll-free number on your identification card. *Platinum PPO Plans only*

Platinum PPO - Group Number P10478 **BCBS Network: Participating Provider Organization**

Plan Features	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual	$350	$700
Family	$350 x 2 = $700	$700 x 2 = $1,400
Medical Out-of-Pocket (excludes Deductible)		
Individual	$1,000 + Copays	$1,000
Family	$1,000 per person + Copays	$1,000 per person
Prescription Maximum Out-of-Pocket		
Individual	No Limit	No Limit
Family	No Limit	No Limit
Total Out-of-Pocket Maximum		
Individual	$1,350 + Copays	$1,700 + prescriptions
Family	$2,700 + $1,000 per Additional Member + Copays	$3,400 + $1,000 per Additional Member + prescriptions
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	First $500 per individual, per calendar year, covered 100% with no deductible or copay. Remainder subject to 80% after deductible	First $500 per individual, per calendar year, covered 100% with no deductible or copay. Remainder subject to 80% after deductible
Office Visit	$20 Copay	80% after Deductible
Inpatient Hospital Services	80% after Deductible	80% after Deductible
Outpatient Surgical Care	80% after Deductible	80% after Deductible
Outpatient Lab & X-ray	100% Deductible Waived	80% after Deductible
Emergency Room Care (Copay waived if admitted)	$150 Copay then 80% after Deductible	$150 Copay then 80% after Deductible
Ambulance	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	80% after Deductible
Rehabilitation Services	80% after Deductible	80% after Deductible
Mental Health/Substance Abuse Inpatient	80% Deductible Waived	80% Deductible Waived
Mental Health/Substance Abuse Outpatient	80% Deductible Waived	80% Deductible Waived
Mental Health/Substance Abuse Office Visit	$20 Copay	80% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***	**Retail**
Level One	$5 / $7.50 Copay	$5 Copay + 25%
Level Two	$30 / $45 Copay	$30 Copay + 25%
Level Three	$50 / $75 Copay	$50 Copay +25%
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	$0 Copay / Not Applicable	Not Applicable

** all maintenance drugs require a 90-day prescription*

Platinum PPO Limited – Group Number 0MB995 **BCBS Network: Blue Choice Select PPO**

Plan Features	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual	$350	$700
Family	$350 x 2 = $700	$700 x 2 = $1,400
Medical Out-of-Pocket (excludes Deductible)		
Individual	$1,000	$2,000
Family	$1,000 x 2 = $2,000	$2,000 x 2 = $4,000
Prescription Maximum Out-of-Pocket		
Individual	$3,000	$3,000
Family	$3,000 x 2 = $6,000	$3,000 x 2 = $6,000
Total Out-of-Pocket Maximum		
Individual	$4,350	$5,700
Family	$8,700	$11,400
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100% Deductible Waived	100% Deductible Waived
Office Visit	$20 Copay	60% after Deductible
Inpatient Hospital Services	80% after Deductible	60% after Deductible
Outpatient Surgical Care	80% after Deductible	60% after Deductible
Outpatient Lab & X-ray	100% Deductible Waived	60% after Deductible
Emergency Room Care (Copay waived if admitted)	$150 Copay then 80% Deductible Waived	$150 Copay then 80% Deductible Waived
Ambulance	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	60% after Deductible
Rehabilitation Services	80% after Deductible	60% after Deductible
Mental Health/Substance Abuse Inpatient	80% Deductible Waived	60% Deductible Waived
Mental Health/Substance Abuse Outpatient	100% Deductible Waived	60% Deductible Waived
Mental Health/Substance Abuse Office Visit	$20 Copay	60% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***	**Retail**
Level One	$5 / $7.50 Copay	$5 Copay + 25%
Level Two	$30 / $45 Copay	$30 Copay + 25%
Level Three	$50 / $75 Copay	$50 Copay +25%
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	$0 Copay / Not Applicable	Not Applicable

** all maintenance drugs require a 90-day prescription*

Gold HDHP – Group Number PA1618 **BCBS Network: Participating Provider Organization**

Plan Features	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual	$3,000	$3,000
Family	$3,000 x 2 = $6,000	$3,000 x 2 = $6,000
Medical Out-of-Pocket (excludes Deductible)		
Individual	$0	$0
Family	$0	$0
Prescription Maximum Out-of-Pocket		
Individual	Not Applicable	Not Applicable
Family	Not Applicable	Not Applicable
Total Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100% Deductible Waived	70% after Deductible
Office Visit	100% after Deductible	70% after Deductible
Inpatient Hospital Services	100% after Deductible	70% after Deductible
Outpatient Surgical Care	100% after Deductible	70% after Deductible
Outpatient Lab & X-ray	100% after Deductible	70% after Deductible
Emergency Room Care	100% after Deductible	100% after Deductible
Ambulance	100% after Deductible	100% after Deductible
Durable Medical Equipment	100% after Deductible	70% after Deductible
Rehabilitation Services	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Inpatient	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Outpatient	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Office Visit	100% after Deductible	70% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***	**Retail**
Level One	100% after Deductible	70% after Deductible
Level Two	100% after Deductible	70% after Deductible
Level Three	100% after Deductible	70% after Deductible
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	Not Covered	Not Covered

** all maintenance drugs require a 90-day prescription*

Gold HDHP Limited – Group Number 0MB996 **BCBS Network: Blue Choice Select PPO**

Plan Features	Participating Provider	Non-Participating Provider
Calendar Year Deductible		
Individual	$3,000	$3,000
Family	$3,000 x 2 = $6,000	$3,000 x 2 = $6,000
Medical Out-of-Pocket (excludes Deductible)		
Individual	$0	$0
Family	$0	$0
Prescription Maximum Out-of-Pocket		
Individual	Not Applicable	Not Applicable
Family	Not Applicable	Not Applicable
Total Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100% Deductible Waived	70% after Deductible
Office Visit	100% after Deductible	70% after Deductible
Inpatient Hospital Services	100% after Deductible	70% after Deductible
Outpatient Surgical Care	100% after Deductible	70% after Deductible
Outpatient Lab & X-ray	100% after Deductible	70% after Deductible
Emergency Room Care	100% after Deductible	100% after Deductible
Ambulance	100% after Deductible	100% after Deductible
Durable Medical Equipment	100% after Deductible	70% after Deductible
Rehabilitation Services	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Inpatient	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Outpatient	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Office Visit	100% after Deductible	70% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***	**Retail**
Level One	100% after Deductible	70% after Deductible
Level Two	100% after Deductible	70% after Deductible
Level Three	100% after Deductible	70% after Deductible
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	Not Covered	Not Covered

** all maintenance drugs require a 90-day prescription*

Dental Plan

Group Number 10458

When you enroll in one of Naperville Community Unit School District 203's medical/prescription plans, you are **automatically** enrolled in the dental plan through Delta Dental. Regular dental checkups are important to your overall health and can reveal early indications of serious conditions like osteoporosis and cardiovascular disease. An oral exam can help keep your teeth and gums healthy throughout your life.

Delta Dental's PPO Plan allows you to see any dentist. However, you will maximize your benefits by visiting a dentist in Delta Dental's PPO Network or Premier Network. Payment to Delta Dental PPO Providers is based on pre-set reduced fees; payment to Premier providers is based on maximum plan allowances. With either network, you are only responsible for your deductible and coinsurance and will not be responsible for charges exceeding the reduced fee or maximum plan allowance. To find a dentist in Delta Dental's PPO or Premier Network, log on to DeltaDentalIL.com or call 1.800.323.1743.

The information below highlights some of the plan features for In-Network services. Please refer to your benefit plan certificate for full coverage information.

Plan Features – Group #10458	PPO Network Provider	Premier Provider
Calendar Year Deductible	$50 per Member	$50 per Member
Annual Maximum	$2,500 per Member	$2,500 per Member
Preventive Services	80% of reduced fee after deductible	80% of maximum plan allowance after deductible
Basic Services	80% of reduced fee after deductible	80% of maximum plan allowance after deductible
Major Services	50% of reduced fee after deductible	50% of maximum plan allowance after deductible
Orthodontic Services (children under age 19)	50% of reduced fee after deductible	50% of dentist's usual fee after deductible
Orthodontia Lifetime Maximum	$2,000 per Member	$2,000 per Member

Preventive Services include oral examinations (two per calendar year), x-rays, cleanings (two per calendar year), topical fluoride treatment (one per benefit year for children under age 15), and space maintainers

Basic Services include fillings, oral surgery, sealants, TMJ, general anesthesia (in conjunction with oral surgery), periodontics, and endodontics (root canals)

Major Services include crowns, fixed/removable bridges, partial/full dentures, and implants

Please note: *Out-of-Network providers are paid on the same schedule as Premier Providers but can bill you for charges above Delta Dental's maximum plan allowances and may require you to pay the entire bill in advance and wait for reimbursement.*

Vision Plan

Group Number 619316

When you enroll in one of Naperville Community Unit School District 203's medical/prescription plans, you are given the **option** to enroll in a vision care plan through Humana Vision. Vision health impacts your overall health. 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. It is recommended that you have an eye exam once every 12 months.

To find an in-network (Insight) provider or download an out-of-network claim form, visit Humana or call 1.866.398.2980.

The information below highlights some of your plan features. Please refer to your benefit plan certificate for full coverage information.

Humana Vision Plan 130 Features	Participating Provider	Non-Participating Provider
Eye Examinations (1x every 12 months)	$10 Copay	$30 allowance
Lenses (1x every 12 months)		
Single	$15 Copay	$25 allowance
Bifocal	$15 Copay	$40 allowance
Trifocal	$15 Copay	$60 allowance
Contact Lenses (1x every 12 months)		
Elective (conventional and disposable)	$130 allowance, 15% discount on professional services	$104 allowance
Medically Necessary	100%	$200 allowance
Frames (1x every 24 months)	$130 allowance	$65 allowance

Members receive additional fixed copays on lens options including anti-reflective and scratch-resistant coatings. Members also receive a 20% retail discount on a second pair of eyeglasses within 12 months of a covered eye exam through the vision care provider who sold the initial pair. If member prefers contact lenses, the plan provides an allowance in lieu of all other benefits (including frames).

Humana Vision contracts with many well-known facilities and eye doctors to offer Lasik procedures at substantially reduced fees. You can take advantage of these low fees when procedures are done by in-network providers. The locations listed below offer the following prices (per eye):

In-Network Provider	Conventional/Traditional	Custom
TLC designated locations only – 888.358.3937	$895	$1,295-$1,895
Lasik*Plus* – 866.757.8082	$695-$1,395	$1,895
QualSight LASIK – 855.456.2020	$895-$1,295	$1,320-$1,995

Payroll Contributions

As an employee of Naperville Community Unit School District 203, you have a variety of benefits. You share the cost of your Medical/Prescription, Dental, and Vision benefits with Naperville Community School District 203, as illustrated in the chart below. Basic Life Insurance and Long Term Disability are provided to you at no cost.

Naperville Community Unit School District 203 withholds premium contributions on a pre-tax basis by use of an Internal Revenue Code Section 125 Premium Conversion Plan. Pre-tax premiums are not subject to Federal, FICA, and in some instances, state taxes. You may request premium contributions to be deducted post-tax by contacting your Employee Benefits Specialist.

Premium contributions for a Civil Union Partner, however, are subject to federal income taxes, and as such, may only be withdrawn through a post-tax payroll deduction.

	EMPLOYEE ONLY*			FAMILY*		
	Full-rate Monthly Premium	**26-pay Employee Contribution**	**20-pay Employee Contribution**	**Full-rate Monthly Premium**	**26-pay Employee Contribution**	**20-pay Employee Contribution**
Medical/Prescription Platinum PPO	$758.34	$52.50	$68.25	$2,268.53	$157.06	$204.17
Medical/Prescription Platinum PPO Limited Network	$535.85	$37.10	$48.23	$1,602.93	$110.97	$144.26
Medical/Prescription Gold HDHP	$483.52	$33.47	$43.52	$1,446.39	$100.13	$130.18
Medical/Prescription Gold HDHP Limited Network	$401.32	$27.78	$36.12	$1,200.53	$83.11	$108.05
Dental	$44.47	$3.08	$4.00	$108.26	$7.50	$9.74
Vision	$5.31	$0.37	$0.48	$13.35	$0.92	$1.20

Contribution amounts listed above assume the following:

- ✓ **Full-time Status** Employee contribution amounts are increased for employees who do not work full time. These employees should refer to their union contracts or contact the Employee Benefits Specialist for specific contribution amounts
- ✓ **Outcome Based Wellness Program Participation** If you, or your spouse/civil union partner under the family plan, decline to participate in the wellness screening or fail meet the requirements of the Outcomes Based Wellness Program, your total yearly premium contribution will increase $300.00 for the employee only plan or $600.00 for the family plan. Employee contributions will be adjusted accordingly on the first payroll in January.
- ✓ **Spousal/Civil Union Partner Surcharge Exemption** If your spouse or civil union partner is eligible for medical coverage through his/her employer that meets the Affordable Care Act's essential benefits, minimum value, and affordability requirements **and** is enrolled in one of the District 203's medical/prescription plans, you will be assessed a surcharge of $175 per month ($80.77 per payroll based on 26 pays and $105.00 per payroll based on 20 pays). The surcharge applies regardless if the District 203 coverage is primary or secondary but does not apply to spouses/civil union partners with non-company sponsored health plans such as COBRA, Medicare and Veteran's Affairs.

Outcomes Based Wellness Program

Wellness begins with awareness and Naperville Community Unit School District 203 continues to take proactive steps to promote overall well-being. District 203 encourages you, and your spouse or civil union partner, if applicable, to participate in the Outcomes Based Wellness Program to receive a bigger picture of your overall health and to help identify any early warning signs of disease.

CHC Wellbeing is on-site to administer the screening, which includes a simple questionnaire, blood pressure and a blood draw. Each participant receives their own confidential summary report that provides an overview of their results, written in non-medical language for easy interpretation.

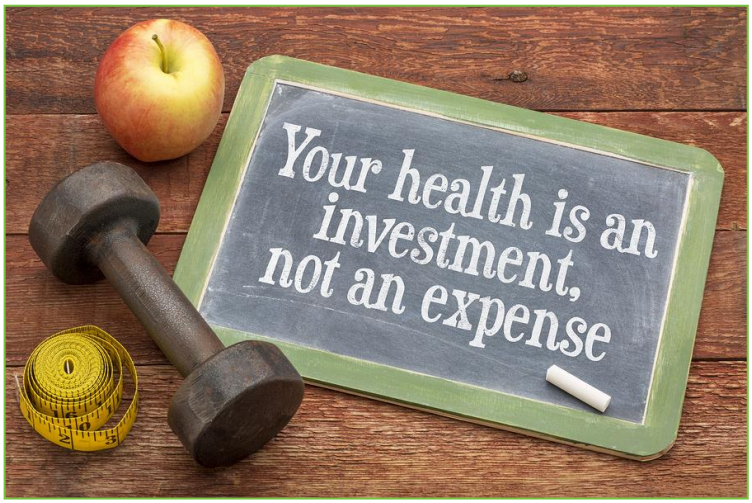
The basic wellness screening is offered at no cost to eligible employees and spouses or civil union partners covered under District 203's medical/prescription Plan. To receive the with-Wellness rate on the medical/prescription monthly premium contribution, both the employee and covered spouse or civil union partner must meet the criteria of the Outcomes Based Wellness Program.

The wellness screening complies with all current HIPAA requirements and is strictly confidential. District 203 receives a general report that combines the entire company's health screening results to assist in continued wellness initiatives; however, CHC does not share any specific individual results.

In preparation for the health screening, it is recommended that you fast 10-12 hours before testing. You may drink black coffee or tea (no cream or sugar) during the fast, and should drink two glasses of water two hours prior to the screening. If you are diabetic or hypoglycemic, please consult your physician for fasting instructions.

Most medications can be taken prior to your screening and will not affect your results. Please consult your physician if you have a question about any medication you are currently using. Those taking insulin should call their doctor regarding their insulin dose the morning of the screening.

Employees, spouses and civil union partners must present their insurance card and employee number at the time of the screening. Screening dates and locations are coordinated by the Benefits Department and communicated to all employees.



Teladoc

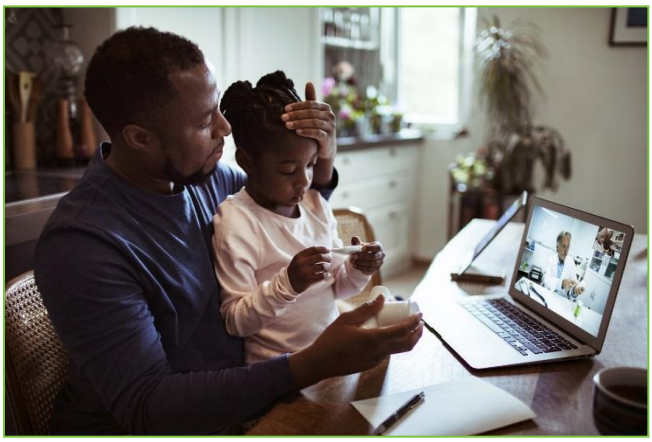
Naperville Community Unit School District 203 offers employees that select one of our health insurance plans access to Teladoc. Teladoc is health care made simple. They are the first and largest provider of telehealth medical consults in the United States, giving you 24/7/365 access to quality health care through phone and video consults. Teladoc has board certified doctors in internal medicine, family practice and pediatrics committed to providing covered employees and families quality health care options. Teladoc does not replace your primary care physician, although it is a convenient and affordable option for quality care. Request a consult anytime and anywhere by phone – 1.800.TELEDOC (835-2362) – or online at Teladoc.com. You will talk with a physician within one hour of setting up your account and calling for a consult. The physician will conduct a medical consult and assess your medical needs.

When can I use Teladoc?

- You need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

What conditions can the doctor evaluate?

- Cold and Flu Symptoms
- Allergies
- Bronchitis
- Urinary Tract Infection
- Respiratory Infection
- Sinus Problems
- Sprains and Strains
- And More!



Who are the doctors at Teladoc?

- Practicing PCPs, pediatricians, and family medical physicians
- Average 15 years of experience
- U.S. board-certified and licensed in your state
- Credentialed every three years, meeting NCQA Standards

What does it cost for a consult with Teladoc?

- Platinum and Platinum Limited Plan members pay $5.00 per consult
- Gold and Gold Limited Plan members pay $50.00 per consult

Teladoc Behavioral Health

Naperville Community Unit School District 203 offers a Behavioral Health option in conjunction with current Teladoc services. Teladoc behavioral health providers are experienced **psychiatrists, psychologists, therapists** and **social workers.** They provide assistance for issues like stress and anxiety, depression, abuse, and more. Quality behavioral health care is available through phone or video. Request a consult by phone – 1.800.TELEDOC (835-2362) – or online at Teladoc.com.

Benefits of using the Behavioral Health option through Teladoc

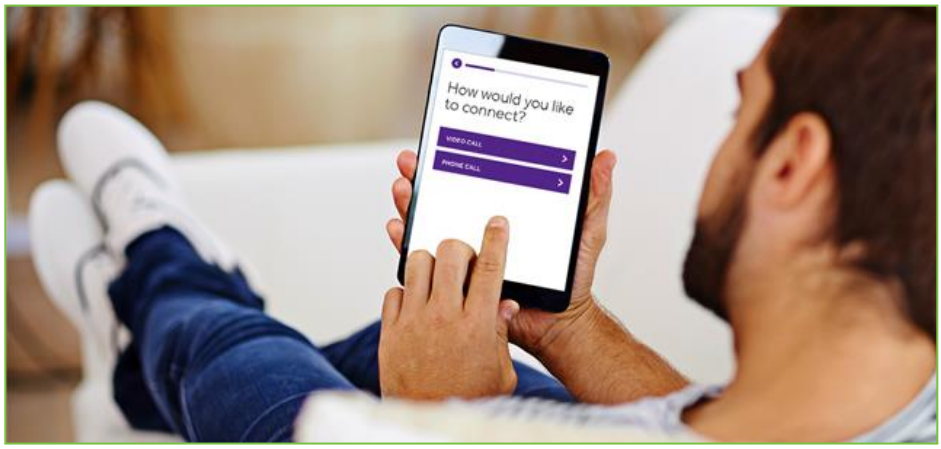
- Can be used from the comfort of your own home, when you are traveling, or if you have a student away at school. It can be accessed from anywhere at anytime
- Can provide significant cost savings versus going in-person
- If there is a need for multiple appointments, you can receive care from the same Behavioral Health expert throughout the duration of treatment

Cost for Platinum Plans

- $20 Copay for the first Behavioral Health Consultation with a psychiatrist
- $20 Copay for all subsequent Behavioral Health Consultations with a psychiatrist
- $20 Copay for each Behavioral Health Consultation with a therapist other than a psychiatrist

Cost for Gold HDHP Plans

- $220 for the first Behavioral Health Consultation with a psychiatrist
- $100 for all subsequent Behavioral Health Consultations with a psychiatrist
- $90 for each Behavioral Health Consultation with a therapist other than a psychiatrist



Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are optional plans offered by Naperville Community Unit School District 203 through PayFlex that allow you to save money by using pre-tax dollars to pay for your out-of-pocket health care and dependent care expenses. The amount you select will be deducted biweekly on a pre-tax basis from your pay (based on 26 or 20 pays). The FSA plan year aligns with the calendar year, running January 1 to December 31.

Health Care Flexible Spending Account (HFSA)

The HFSA allows you to pledge pre-tax money for qualified health care expenses that you, your spouse and/or your dependent children incur throughout the plan year. You do not need to be enrolled in medical, dental or vision coverage through the District to enroll in the HFSA.

- You may contribute up to $2,850 to your HFSA for the 2023 Plan Year. This contribution limit is subject to change per IRS regulations.
- Your share of expenses which are not reimbursed by a health care plan, such as copays, deductibles, and out-of-pocket expenses, are eligible to be claimed from the HFSA plan.

The IRS and Naperville Community Unit School District 203 allow you to claim any unused HFSA amounts after the end of the plan year for expenses incurred until March 15 of the new plan year. All claims, including those incurred during the grace period, must be submitted by March 31. The “Use It or Lose It” rule applies to any funds left in your HFSA account after the grace period has expired.

Dependent Care Flexible Spending Account (DCA)

The DCA allows you to pledge pre-tax money for qualified dependent care expenses you incur throughout the plan year. Eligible dependents are those whom you are entitled to claim as dependents on your federal tax return, are under age 13, and/or a disabled spouse or other disabled tax-qualified dependent who spends at least eight hours a day in your home. If you are married, your spouse must also work, be a full-time student or be disabled.

- You may contribute up to $5,000 to your DCA for the 2023 Plan Year if you are single or if you are married and file a joint return.
- You may contribute up to $2,500 to your DCA for the 2023 Plan year if you are married and file separate income tax returns.
- Expenses such as day care, before- and after-school programs, summer day camp and adult day care are eligible to be claimed from the DCA plan.

All DCA expenses must be incurred during the plan year and submitted by March 31. The “Use It or Lose It” rule applies to any DCA funds left in your account at the end of the plan year. There is no grace period for the DCA.

Health Savings Account

If you enroll in the Gold PPO HDHP or Gold PPO HDHP Limited Network medical/prescription plan offered by Naperville Community School District 203, you may be eligible to open a Health Savings Account (HSA) with Lively to help you save pre-tax dollars to pay for out-of-pocket health care expenses. The funds in your HSA belong to you and may be used tax-free for current or future IRS qualified medical expenses or may be left to accumulate for use during retirement. The funds deposited into the account and the earnings are tax-deferred; funds withdrawn for IRS qualified medical expenses are tax-free.

To be eligible to open or contribute to an HSA, you must be:

- ✓ Covered by a qualified HDHP
- ✓ Not enrolled in Medicare
- ✓ Not listed as a dependent on another person's income tax return
- ✓ Not covered by another non-HSA qualified medical plan – including an HFSA

Your spouse's non-HSA qualified coverage does not affect your ability to contribute to an HSA as long as it does not cover you. However, if you or your spouse participates in a Health Flexible Spending Account (HFSA), you are considered "covered" by a non-HSA qualified plan and as such cannot contribute to an HSA unless the FSA is limited-purpose and applies only to dental and/or vision expenses.

***Note for Annual Benefits Enrollment*:** If you switch to one of the Gold high deductible health plans from a Platinum plan and have a health care flexible spending account, the balance in your HFSA account must be zero ($0.00) on December 31, 2022. If you carry any balance into the following year, you cannot become HSA-eligible until the first day of the month after the grace period ends – April 1, 2023. Your 2023 total HSA contribution cannot exceed the maximum based on a nine-month year. The employer contribution to your Health Savings Account will be prorated accordingly, as well as your employee contribution, as applicable. If you have funds in your HFSA, you may continue to claim expenses against your HFSA through the grace period.

Contributions to an HSA may be made by an employee using pre-tax payroll deductions, bank deposits, or a one-time rollover from an IRA, as well as those made by District 203. HSA contributions are limited by the U.S. Internal Revenue Service based on the calendar year. The maximum amount that can be contributed to an HSA for 2023 (employee and employer contributions combined) is $3,850 for employee only coverage and $7,750 for family coverage. Individuals over age 55 may make an additional "catch-up" contribution of $1,000 annually.

District 203 has committed to contributing to the Lively HSA of each eligible employee who participates in the Gold PPO HDHP or Gold PPO Limited HDHP for the 2023 Plan Year. District 203 will contribute $1,250 for employee only coverage and $2,500 for family coverage to employees who remain in or elect a high-deductible health plan during Annual Benefits Enrollment. District contributions are deposited on the **first payroll in January 2023**. For the balance of the year, contributions will be prorated for employees not eligible for an HSA for the entire year. **An HSA application must be completed and returned to the Benefits Department for processing before payroll contributions can begin.**

You may withdraw funds from your HSA for any purpose at any time. However, funds withdrawn for reasons other than IRS qualified medical expenses will be taxed and, for those under age 65, subject to a penalty. Funds for IRS qualified medical expenses may be withdrawn tax- and penalty-free as long as the expenses are incurred after the HSA was established. You may even use HSA funds tax- and penalty-free for the qualified medical expenses of your IRS-defined tax dependents even if they are not covered under the HDHP. Qualified medical expenses are defined under Section 213 of the IRS Code (see IRS Publication 502).

If at any point, you no longer meet the eligibility requirements for an HSA, you may no longer make contributions. However, the balance of your HSA will not be affected and you may use any existing funds in your account to pay for IRS qualified medical expenses tax-free (even if you no longer have HDHP coverage) or continue to save the funds with tax-free interest until used. If you are not HSA eligible for the entire tax year, it is generally prudent to prorate your contributions.

Life and AD&D Plan

Planning your financial security is a challenging task under the best of circumstances, but what happens if you die or are sidelined due to a lengthy illness or injury? How will your family pay the monthly bills? That's where your income protection benefits come into play. One of those benefits is life insurance.

Naperville Community Unit School District 203 provides basic life insurance and accidental death and dismemberment (AD&D) insurance through Reliance Standard Life Insurance at no cost to you. The information below highlights some of the plan features. Please refer to your benefit plan certificate for full coverage information.

- **Life Insurance** See chart below for benefits. The amount of benefit will be reduced to 65% at age 70 and will be further reduced to 50% at age 75
- **Accidental Death or Dismemberment (AD&D)** Your beneficiary will receive 100% of benefit upon your death or if you lose two of the following: hand, foot and/or eye. Fifty percent of benefit will be paid for loss of one hand, one foot or sight of one eye
- **Accelerated Benefit (Living Benefit)** If you have been diagnosed with a terminal illness and life expectancy is 24 months or less, you can receive 75% of the life benefit. Please note: your death benefit would be reduced by the amount taken through the accelerated benefit upon your death ($37,500 provided through Living Benefit and $12,500 provided upon death for a total benefit of $50,000)
- **Convertible** You may convert your policy to an individual whole life policy within 31 days of termination of employment without submitting evidence of insurability

Eligibility	Life Benefit	AD&D Benefit
Active full-time administrator, non-union personnel, NUEA, NESPA, NTA and NUMA staff; except any person employed on a temporary or seasonal basis	$50,000*	Same as life amount

** Minimum life benefit*

Please note: *In the event of Total Disability, it is your responsibility to file a Waiver of Premium with Reliance Standard to extend your life insurance coverage. You must submit proof of Total Disability within one year from the date the disability began, and resubmit annual proof thereafter, to continue to extend your benefits an additional 12 months until retirement or up to 12 months past age 65.*

Long Term Disability Plan

Long Term Disability (LTD) is another income protection benefit offered to you at no cost by Naperville Community Unit School District 203. Long Term Disability replaces a portion of your earnings if you are disabled for an extended period of time due to illness or injury. All full-time active employees are eligible for Long Term Disability coverage through Reliance Standard Life Insurance.

The information below highlights some of the plan benefits. Please refer to your benefit plan certificate for detailed information.

- Benefits begin after 60 consecutive days of disability or the day allotted/accrued sick time is exhausted, whichever is greater
- Pays 60% of basic monthly income up to a maximum of $7,500 per month
- Benefits continue until you reach your normal retirement age under Social Security, as long as you continue to be disabled
- Benefits may be available if working on a part-time basis while disabled
- Survivor benefit is equal to three times the insured's last monthly benefit if death occurs after 180 consecutive days of total disability

Please note: Definition of disabled changes after 60 months of disability. For the first 60 months, you are considered disabled if unable to perform the material duties of your regular occupation. After that time, you are considered disabled if you are unable to perform the material duties of any occupation for which you are suited by education, training, or experience.

Voluntary Life Insurance Plan

Naperville Community Unit School District 203 provides all eligible employees with the opportunity to purchase additional life insurance at group rates through Reliance Standard Life Insurance. You pay the full cost of this coverage through after-tax payroll deductions. The information below highlights some of the plan features; please refer to your benefit plan certificate for full coverage information.

Insured	Benefit	Guaranteed Issue Amount
New Employee	Option of $10,000 to $500,000 in increments of $10,000	Under Age 60: $150,000 Age 60 - 70: $10,000
Current Employee	Option of $10,000 to $500,000 in increments of $10,000	Under Age 60: $150,000 Age 60 - 70: $10,000
Spouse/Civil Union Partner	Option of $10,000 to $500,000 in increments of $10,000	Under Age 60: $50,000 annually
Dependent Children	14 days to 6 months: $1,000 6 months to Age 26: Choice of $10,000 or $20,000	$20,000

Employees eligible for supplementary life insurance are active employees working 25 or more hours per week, except those working on a temporary or seasonal basis. Legal spouses of eligible employees and domestic or civil union partners where required by law, are eligible under age 75 but must be under age 70 on the date of application. All Guaranteed Issue amounts are for current plan year and may change in future years.

All employee and spouse/civil union partner premium rates are age-banded and based on the age at last birthday. The premium rate may change during the plan year if the insured enters a new age band at the time of the insured's birthday.

Employee and Spouse/Civil Union Partner Rate per Person per $10,000 per Month

Age	Non-Tobacco User	Tobacco User
Under 30	$0.54	$0.91
30 - 34	$0.57	$1.15
35 - 39	$0.87	$1.82
40 - 44	$1.47	$3.16
45 - 49	$2.56	$5.52
50 - 54	$4.47	$9.42
55 - 59	$7.95	$14.94
60 - 64	$9.69	$15.99
65 - 69	$14.37	$21.27
70+	$26.53	$36.34

Eligible children are unmarried, financially dependent natural, adopted, foster or stepchildren in the custody of an eligible employee. One rate applies for all eligible dependent children in the family, regardless of number. Coverage for dependent children terminates at age 26 but is extended up to age 30 if dependent child is an Illinois resident honorably discharged from the armed forces. Children beyond age 26 will continue to be covered if they are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and are chiefly dependent on the eligible employee for support and maintenance. **Employee must elect employee voluntary life coverage and/or spouse voluntary life coverage in order to elect voluntary child life coverage.**

Dependent Children Rate per Month

	Option 1	Option 2
Coverage amount from age 14 days to 6 months	$1,000	$1,000
Coverage amount from age 6 months to 26 years	$10,000	$20,000
Rate	$1.62	$3.25

To comply with the Age Discrimination in Employment Act (ADEA), the following reduction formula applies to insured employees (spouses/civil union partners are ineligible as of age 75):

Age	Amount of Coverage Reduces to:
75 - 79	60.0% of the amount in force at age 74
80 - 84	35.0% of the amount in force at age 74
85 - 89	27.5% of the amount in force at age 74
90 - 94	20.0% of the amount in force at age 74
95 - 99	7.5% of the amount in force at age 74
100 and over	5.0% of the amount in force at age 74

Guaranteed Issue Benefit issue amounts are guaranteed to a certain level without regard to health status if enrollment occurs within 31 days of your effective date. The guaranteed issue amount is up to $150,000 for new and current employees under age 60. Spouses/civil union partners under age 60 are guaranteed an issue of up to $50,000 and dependent children are guaranteed an issue of up to $20,000. If you apply for benefits above the guaranteed issue amounts, you may be subjected to evidence of insurability and a health screening prior to coverage approval.

Accelerated Benefit (Living Benefit) If you are under age 75 and have been diagnosed with a terminal illness and life expectancy is 24 months or less, you can receive 50% of the life benefit. You can utilize this money for expenses incurred that are not covered by other insurance for your care. *Please note: your death benefit would be reduced by the amount taken through the accelerated benefit upon your death.*

Portability Coverage can continue if the insured no longer meets the employment eligibility requirements for reasons other than over-all termination of the group policy. Premiums charged will be based on the prevailing rate charged to all insured who continue coverage under this provision and will be billed directly to the insured.

Voluntary Critical Illness Plan

Critical Illness Insurance helps you reduce the potential financial impact of serious illness by providing a lump-sum cash payment upon diagnosis of a covered condition. Naperville Community Unit School District 203 offers employees the ability to purchase Critical Illness coverage for themselves and their dependents at group rates through Reliance Standard. You pay the full cost of this coverage through convenient after-tax payroll deductions. The information below highlights some of the plan features; please refer to your benefit plan certificate for full coverage information.

Insured	Benefit	Guaranteed Issue Amount
Employee	Option of $5,000 to $50,000 in increments of $1,000	$15,000
Spouse/Civil Union Partner	Option of $5,000 to $50,000 in increments of $1,000	$15,000
Dependent Children	25% of Employee's Benefit limited to $12,500 maximum	$12,500

Employees eligible for Critical Illness Insurance are active employees working 25 or more hours per week, except those working on a temporary or seasonal basis. Legal spouses of eligible employees and domestic or civil union partners where required by law, are eligible under age 75 but must be under age 70 on the date of application. Employees must be enrolled in the Critical Illness plan to extend coverage to their spouses/civil union partners and/or dependent children.

Employee and Spouse/Civil Union Partner Rate per Person per $1,000 per Month

Age	Rate	Age	Rate
Under 30	$0.338	60 - 64	$4.898
30 - 34	$0.537	65 - 69	$6.975
35 - 39	$0.699	70- 74	$8.938
40 - 44	$1.073	75 - 79	$11.98
45 - 49	$1.716	80 - 84	$14.922
50 - 54	$2.577	85+	$23.902
55 - 59	$3.482		

All employee and spouse/civil union partner premium rates are age-banded and based on the age at last birthday. The premium rate may change during the plan year if the insured enters a new age band at the time of the insured's birthday. The benefit amount for employees and spouses/civil union partners will reduce 50% upon the employee's attainment of age 70.

Eligible children are unmarried, financially dependent natural, adopted, foster or stepchildren under age 26 in the custody of an eligible employee. Coverage for dependent children terminates at age 26 but is extended up to age 30 if the child is an Illinois resident honorably discharged from the armed forces. Children beyond age 26 will continue to be covered if they are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and are chiefly dependent on the eligible employee for support and maintenance.

Dependent Children Rate per $1,000 per Month

	Rate
All eligible dependent children in family, regardless of number	$0.247

Covered Critical Illnesses fall into one of three categories:

Cancer Related Life Threatening Cancer, Carcinoma in situ

Cardiovascular Related Heart Attack, Stroke, Coronary Artery Bypass

Other Kidney (Renal) Failure, Major Organ Transplant

Plan Features	Benefit
Diagnosis of Heart Attack, Life Threatening Cancer, Stroke, Major Organ Transplant, or Kidney (Renal) Failure	Basic: 100% of amount in force
Diagnosis of Coronary Artery Bypass or Carcinoma in situ	Partial: 25% of amount in force
Recurrence (Same Category) diagnosis must be separated by at least 18 months	50% of Basic or Partial Benefit
Subsequent Occurrence (Differed Category) diagnosis must be separated by at least 6 months	100% of Basic or Partial Benefit
Lifetime Maximum Benefit per Category	200% of amount in force
Completion of Wellness / Health Screening	$50 per 12-month period

Guaranteed Issue Benefit issue amounts are guaranteed to a certain level without regard to health status if enrollment occurs during the Annual Benefits Enrollment period or within 31 days of first becoming eligible. The guaranteed issue amount is up to $15,000 for employees and spouses/civil union partners and $12,500 for dependent children. If you apply for benefits above the guaranteed issue amount, or apply outside your initial eligibility or the Annual Enrollment period, you may be subject to evidence of insurability and a health screening prior to coverage approval.

Pre-Existing Conditions For the first 12 months of coverage, benefits will not be paid for any pre-existing condition, whether specifically diagnosed or not, that began during the 12 months prior to your effective date.

Waiting Period There is a 30-day waiting period after your effective date. No benefit will be paid for any condition diagnosed before or during the waiting period.

Portability After coverage has been in effect for at least 12 months, coverage can continue if the insured no longer meets the employment eligibility requirements for reasons other than retirement or overall termination of the group policy. Premiums charged will be based on the prevailing rate charged to all insured who continue coverage under this provision and will be billed directly to the insured.

Voluntary Accident Plan

Accident Insurance can help lessen your financial burden by providing a lump-sum cash payment upon accidental injury. Naperville Community Unit School District 203 offers employees the ability to purchase accident coverage for themselves and their dependents at group rates through Reliance Standard. You pay the full cost of this coverage through convenient after-tax payroll deductions. The information below highlights some of the plan features; please refer to your benefit plan certificate for full coverage information.

	Plan A	Plan B	Plan C
Wellness Screening	$50	$75	$100
Ambulance	$100	$150	$200
Emergency Treatment	$150	$200	$250
Diagnostic Examination	$100 per CT/MRI Scan	$200 per CT/MRI Scan	$400 per CT/MRI Scan
Hospital Admission	$500	$1,000	$1,500
ICU Hospital Admission	$1,000	$1,500	$2,250
Hospital Confinement	$200/day 365-day max	$250/day 365-day max	$350/day 365-day max
ICU Confinement	$400/day 30-day max	$500/day 30-day max	$700/day 30-day max
Non-Surgical Fracture (2x benefit for surgical repair)	Up to $2,500	Up to $3,750	Up to $5,000
Non-Surgical Dislocation (2x benefit for surgical repair)	Up to $1,600	Up to $2,400	Up to $3,200
Transfusion	$200	$300	$400
2nd Degree Burn (8x benefit for 3rd Degree Burn)	Up to $800	Up to $1,600	Up to $3,200
Concussion	$100	$150	$200
Exploratory Surgery	$100	$150	$200
Knee Cartilage Surgery	$300	$450	$800
Abdominal/Thoracic Surgery	$1,000	$1,500	$2,000
Ruptured Disc Surgery	$500	$750	$1,000
Physical Therapy	$25/session, 6 max	$35/session, 6 max	$50/session, 6 max
Accidental Death - Employee	$25,000	$50,000	$100,000
Accidental Death - Spouse	$12,500	$25,000	$50,000
Accidental Death - Children	$5,000	$10,000	$20,000
Dismemberment - One member	50% of Death Benefit	50% of Death Benefit	50% of Death Benefit
Dismemberment - Two or more members	100% of Death Benefit	100% of Death Benefit	100% of Death Benefit

Employees eligible for Accident Insurance are active employees under age 70 at application, working 25 or more hours per week, except those working on a temporary or seasonal basis. Employees must be enrolled in the Accident plan to extend coverage to their spouses/civil union partners and/or dependent children. Eligible spouses are the legal spouses of eligible employees, and domestic or civil union partners where required by law, who are under age 70 at application. Eligible children are unmarried, financially dependent natural, adopted, foster or stepchildren under age 26 in the custody of an eligible employee. Coverage for dependent children terminates at age 26 but is extended up to age 30 if the child is an Illinois resident honorably discharged from the armed forces. Children beyond age 26 will continue to be covered if they are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and are chiefly dependent on the eligible employee for support and maintenance.

Monthly Rates

	Plan A	Plan B	Plan C
Employee Only	$6.24	$9.65	$14.54
Employee and Spouse/Civil Union Partner	$10.08	$15.33	$22.79
Employee and Child(ren)	$11.86	$18.25	$27.52
Family	$18.61	$28.59	$43.01

Accidental Death & Dismemberment AD&D benefits are reduced to 50% for employees and spouses/civil union partners at age 65 to 25% at age 70.

Limitations No benefit will be paid for loss due to sickness, disease, self-infliction or intoxication. Benefits are only paid if the insured sustains an injury due to a covered accident and meets all of the requirements defined for payment under a specific benefit.

Portability After coverage has been in effect for at least 12 months, coverage can continue if the insured no longer meets the employment eligibility requirements for reasons other than retirement or overall termination of the group policy. Premiums charged will be based on the prevailing rate charged to all insured who continue coverage under this provision and will be billed directly to the insured.

Retirement Savings Plan

Naperville Community Unit School District 203 offers employees the opportunity to save for retirement by participating in a 403(b)/457 retirement saving plan.

A 403(b) plan allows you to contribute a portion of your compensation on a **pre-tax** basis in order to save for your retirement. The pre-tax contributions are made to the plan by payroll deduction and grow tax-free until they are withdrawn. This means you are lowering your taxable income now, and will potentially lower the amount of income tax you will pay on your retirement funds at the time of withdrawal, as you may be in a lower tax bracket then. The District 403(b) plan also allows you to contribute a portion of your compensation on a **post-tax** (Roth) basis. These contributions are also made to the plan by payroll deduction.

All employees are eligible to make contributions to these plans.

US OMNI is our third party administrator for these plans. A list of approved investment providers and contribution documents can be found on our plan page at omni403b.com/plandetail/1452. If you wish to increase or decrease your plan contributions or request any additional services (such as loans or withdraws), you will find those forms at this site as well. US OMNI's customer service line is 877-544-6664.

In 2022, you may contribute up to $19,500 to both your 403(b) plan and your 457(b) plan. The Limit for 2023 has not been set yet by the IRS. You may be eligible for additional 403(b) contributions if you will be age 50 or older in the 2023 calendar year or if you have completed at least 15 years of employment with Naperville 203 in 2023. Please reach out to US OMNI to see if you qualify for the additional contribution options. The contribution limits are subject to change per IRS regulations.

This information is for educational purposes only and is not intended as tax or legal advice. Neither your employer nor the investment providers offering retirement savings products can provide you with tax or legal advice. Employees are encouraged to contact their financial representative or tax professional with any questions.

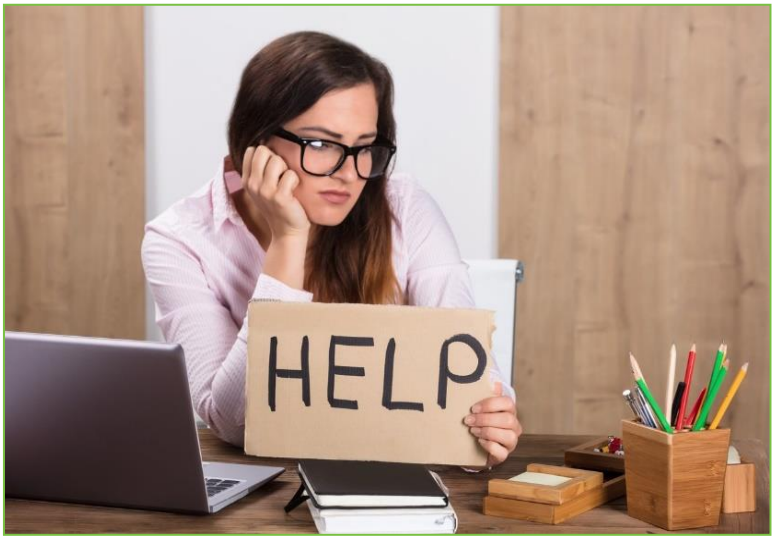
Employee Assistance Program

Everyone needs a little help now and then dealing with stress, work or family issues, or personal concerns. Naperville Community Unit School District 203's Employee Assistance Program (EAP) provides confidential services through a network of licensed counselors and professionals to help you get your life back in balance. The EAP is offered at no cost and is available to all employees and their families. To access the EAP, please call 888.933.1327 or visit the EAP informational website.

The EAP provides in-person or over-the-phone support with short term counseling, referrals to service providers within your insurance network and local area and 24-hour emergency access to licensed professionals on a wide range of issues including but not limited to:

- Marital/Family/Relationship Issues
- Stress
- Depression/Anxiety
- Addiction or Substance Abuse Problems
- Work-Related Conflicts
- Grief and Loss
- Financial Problems
- Legal Difficulties
- Child Care or Elder Care Needs

Participation in the EAP is strictly confidential. All records and discussions between you and an EAP counselor remain confidential unless you authorize disclosure in writing. EAP records are not included in your personnel file.



Health Care Terms

To help you understand how your health plans work, please review the following terms and definitions.

Calendar Year Deductible The amount a member pays out-of-pocket for services before plan co-insurance is applied.

Co-Insurance The percentage of medical costs that a member shares with the insurance company after deductibles are met.

Copay The amount a member pays for specific treatment or prescription drug. This is usually payable at the time of service and does not apply toward the deductible.

Emergency Room vs. Urgent/Immediate Care Emergency rooms are meant for life threatening illnesses or emergency accidents. They are for things like chest pain, breathing problems, and excessive bleeding. If you need to be seen by a doctor for something other than an emergency and cannot wait for an appointment with your regular physician, try using an Urgent/Immediate Care Center. These centers are designed to treat you in an office visit setting. The cost to you may be less than using an emergency room.

Generic Drugs Generic drugs have the same active ingredients as their brand name counterparts with no compromise in quality, yet they are 40% to 60% less expensive. Generic drugs cost less because they do not require the same costly research, development and sales expenses associated with brand name drugs.

In-Network You are considered to be in-network if you visit providers that participate with your health plan. In-network coverage means the plan will pay a higher percentage of benefits and you will have lower out-of-pocket costs. Participating providers have signed contracts to accept discounted or negotiated fees as payment in full.

Medical Out-of-Pocket The total a member will pay in co-insurance and medical copays in the calendar year excluding deductible.

Out-of-Network You are considered to be out-of-network if you visit a provider that has chosen not to participate with your health plan (non-participating providers). Non-participating providers do not have contractual arrangements with the insurance carrier and can bill for charges in excess of your plan's maximum allowable fee. These charges are in addition to the higher deductibles and co-insurance amounts that apply to your out-of-network benefits.

Plan Year The benefit plan year is January 1 through December 31.

Preventive Services Physicals and eligible non-diagnostic tests, well baby/child exams, eligible immunizations, and wellness visits as defined by the plan (Platinum PPO) or U.S. Preventive Services Task Force (Gold HDHP).

Total Out-of-Pocket Maximum The maximum amount a member could pay per calendar year, including deductible, copays and co-insurance but excluding premiums; balance of billed charges out-of-network; and health care expenses the plan does not cover.

Semi-Annual Notice Regarding Health Insurance Coverage for Dependents

Illinois law requires your Health Plan to allow dependents the right to elect or continue coverage until the dependent reaches the age of 26 (and until the age of 30 for military veteran dependents).

Enrollment Period Aside from your initial eligibility to participate in your Plan, you may elect coverage of any dependent not currently covered under the Plan during the Plan's Annual Benefits Enrollment period. If the Plan does not have an open enrollment period, coverage election may occur during the 31-day period prior to the Plan's annual renewal date. The effective date of coverage for each newly enrolled dependent will be governed by the terms of your Plan's summary plan description.

Military Veterans In connection with military veteran dependents 26 years of age and older, such dependents must 1) reside in Illinois; 2) not be married; 3) have served in the active or reserve components of the United States Armed Forces, including the National Guard; 4) have received a release or discharge other than a dishonorable discharge; and 5) have submitted a proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information as to how to obtain a copy of the DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the United States Department of Veterans' Affairs at 1-800-827-1000.

Cost Your employer may require you to pay all or part of the cost of the extended dependent coverage for military veterans from the age of 26 to 30, which may be taxable. For additional information, please consult your benefits department.

Notice of Platinum PPO Grandfather Status

If you are considering enrolling, or are already enrolled in, the Platinum PPO Plan, please read this notice carefully

This group health plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employee Benefits Specialist. You may also visit www.dol.gov/ebsa/healthreform which has a table summarizing which protections do and do not apply to grandfathered health plans.

Important Notice Regarding Medicare

If you are considering joining a Medicare drug plan, please read this notice carefully.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Plan has determined that the prescription drug coverage offered by your Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back. *Please contact your Employer Benefits Specialist for more information about what happens to your coverage if you enroll in a Medicare Part D prescription drug plan.*

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. After 63 continuous days without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, after 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact your Employee Benefits Specialist for further information. **This is a yearly notice**. You will also get it before the next period you can join a Medicare drug plan and if your current drug coverage changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

Detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help for paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security website at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice of Employer Contributions to HSAs

Naperville Community Unit School District 203 provides contributions to the Health Savings Account (HSA) of each eligible employee who is enrolled in the District's Gold HDHP or Gold Limited HDHP. For 2023, the District will load the entire annual contribution from the District on the first payroll in January 2023. If you are an eligible employee, you must do the following in order to receive an employer contribution:

1. Establish a Lively HSA account on or before the last day in February of 2024 and;
2. Notify your Employee Benefits Specialist of your HSA account information (Lively account number) on or before the last day in February of 2024 in writing or by email.

If you establish your HSA on or before the last day of February in 2024 and notify District 203 of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for 2023 by April 15, 2024. If, however, you do not establish your HSA or you do not notify the district of your HSA account information by the deadline, this district is not required to contribute to your HSA for 2023.

If you have any questions about this notice, please contact your Employee Benefits Specialist.

Federal Notices

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires plans which provide mastectomy coverage to provide notice to individuals of their right to benefits for breast reconstruction following a mastectomy.

Benefits for medical and surgical treatment of reconstruction in connection with a mastectomy are further clarified as follows according to the requirements of the Act:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Coverage for prostheses and treatment of physical complications of mastectomy, including lymphedemas, in the manner determined in consultation with the attending physician and the patient

If you would like more information about the benefits available for mastectomy related services, please refer to your Plan Document/Summary Plan Description or call your Plan Administrator.

Notice Regarding Outcomes Based Wellness Program

Naperville Community Unit School District 203's Wellness Program is a voluntary wellness program available to all employees, spouses and retirees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a 37 panel blood test for anemia, infections and certain cancers; heart disease and stroke; kidney diseases; nutritional and gastrointestinal disorders; liver and gallbladder issues, diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees and spouses on the Naperville District 203 BlueCross BlueShield health plan who choose to participate in the biometric screening as well as achieve certain health-related activities will be eligible to receive the with-Wellness premium for the 2023 plan year. Although you are not required to complete the HRA, participate in the biometric screening and achieve certain health-related outcomes, only employees and spouses who do so will be eligible to receive the with-Wellness premium for the 2023 Plan Year. If you are unable to participate or achieve the goals of the program, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting CHC Wellbeing at 866.373.4242.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and e-Learning courses. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Naperville District 203 may use aggregate information it collects to design a program based on identified health risks in the workplace, CHC Wellbeing will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a CHC Wellbeing medical director, a CHC Wellbeing health coach, a CHC Wellbeing account manager in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Director of Human Resources Gretchen Gallois at ggallois@naperville203.org.

Privacy Practices Notice

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. The privacy of your medical information is important to Naperville Community Unit School District 203.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact Human Resources 630.420.6300.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as mutually agreed upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the beginning of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the beginning of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the beginning of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and
2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the beginning of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact Human Resources to obtain this notice in written form.

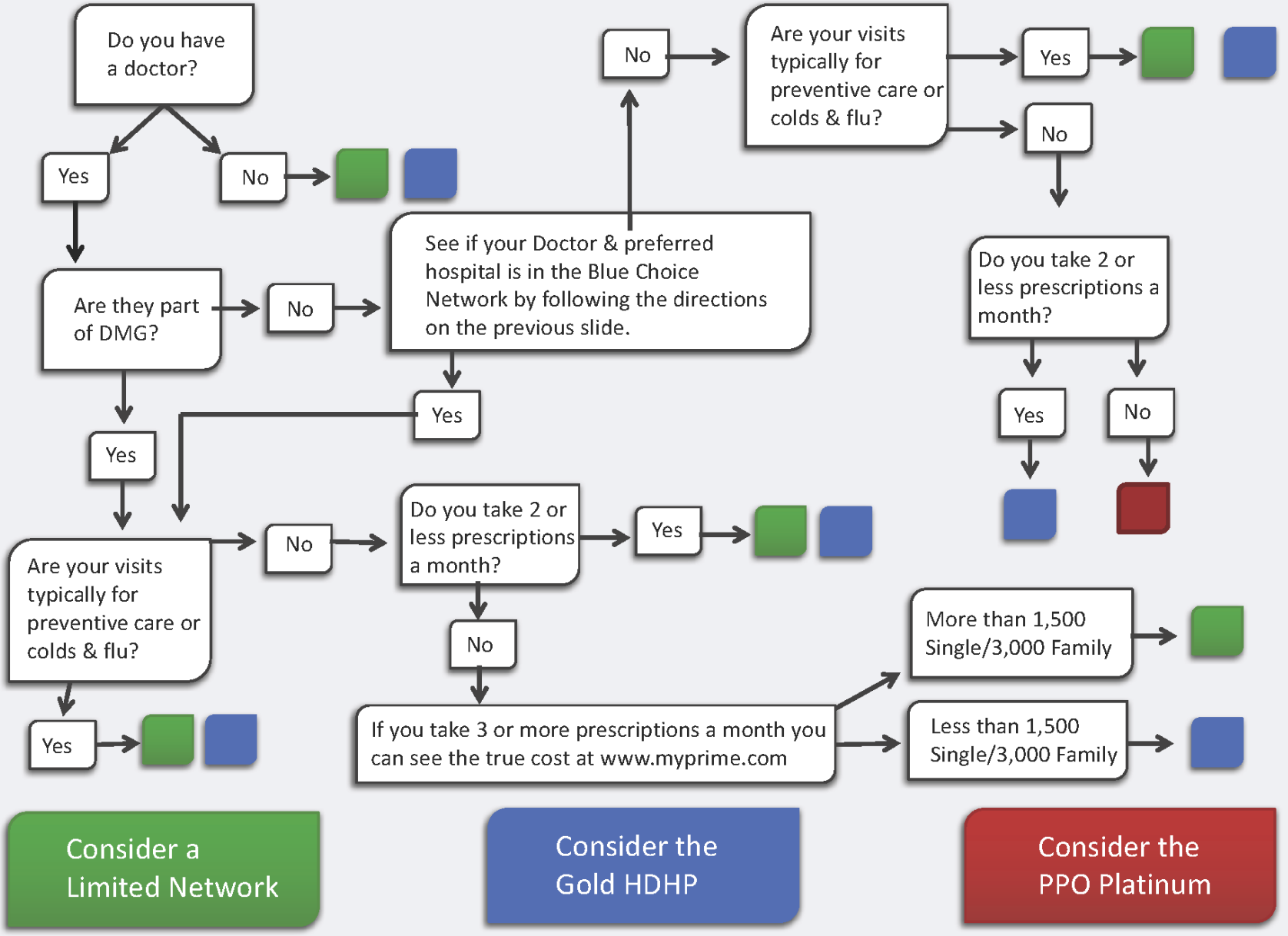
Complaints

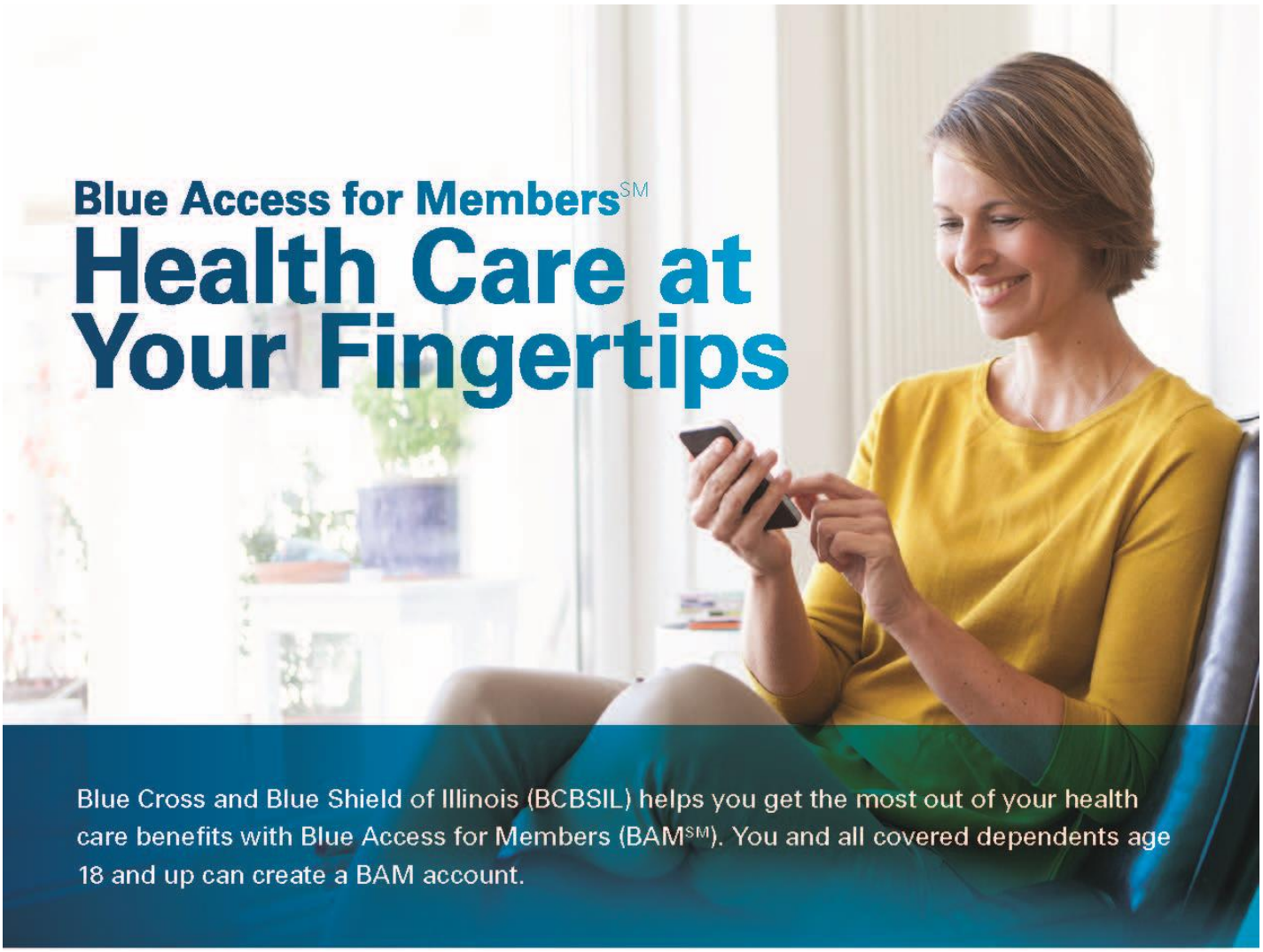
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1.800.368.1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix A


Do you have a doctor?
Yes
No
Are they part of DMG?
No
See if your Doctor & preferred hospital is in the Blue Choice Network by following the directions on the previous slide.
Yes
Yes
Are your visits typically for preventive care or colds & flu?
No
Do you take 2 or less prescriptions a month?
Yes
Yes
No
No
Are your visits typically for preventive care or colds & flu?
Yes
Do you take 2 or less prescriptions a month?
Yes
No
If you take 3 or more prescriptions a month you can see the true cost at www.myprime.com
More than 1,500 Single/3,000 Family
Less than 1,500 Single/3,000 Family
Consider a Limited Network
Consider the Gold HDHP
Consider the PPO Platinum



Blue Access for Members℠
Health Care at Your Fingertips

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

With BAM, you can:

- Use our Provider Finder® tool to search for a health care provider, hospital or pharmacy
- Request or print your ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Use our Cost Estimator tool to find the price of hundreds of tests, treatments and procedures
- Download our app
- Sign up for text or email alerts

It's Easy to Get Started!

1 Go to bcbsil.com/member

2 Click Log Into My Account

3 Use the information on your BCBSIL ID card to sign up

Or, text* BCBSILAPP to 33633 to get the BCBSIL App that lets you use BAM while you're on the go.

*Message and data rates may apply.

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

22195.0419

BlueCross BlueShield of Illinois

The Edge You Get with Blue Choice Select PPO℠

Quality health insurance designed to give you access to a value-based network of contracting physicians and hospitals at an affordable cost.

The Blue Choice PPO network offers access to a select set of independently contracted hospitals and physicians in the Chicago and Quad Cities service areas*. As a Blue Choice Select PPO member, you must live or work within the geographic area that the Blue Choice PPO network serves (additional information is available in the Benefit Booklet).

The hospital network is based on geographic accessibility, the number of board-certified physicians on staff and status with the Joint Commission on Accreditation of Healthcare Organizations, which is the organization that accredits hospitals in the U.S. Besides being an affordable network option, the independently contracted providers also meet the quality thresholds that Blue Cross and Blue Shield of Illinois (BCBSIL) sets for all its networks.

The Blue Choice Select PPO benefit plan gives you the freedom to self-direct your care without having to select a primary care physician or obtain a referral for specialist care. Benefit plans within the network are designed to include deductibles and copayments for certain services.

Take an active role in managing your health care and out-of-pocket costs

For specific information about the benefits your employer offers, including copayments or limits on care, see your Summary of Benefits and Coverage or your Health Care Benefit Program Certificate booklet.

You and your covered family members can receive care from any licensed doctor, hospital or other provider. However, when you use a contracting Blue Choice PPO network provider, you will pay less out of pocket, you won't have to file any claims and you will receive the highest level of benefits. If you use a doctor or hospital in Illinois, but outside the network, you'll still be covered, but your out-of-pocket costs will be significantly higher.

What do you get with Blue Choice Select PPO?

- BCBSIL is a trusted name in health care benefits. Blue Choice Select PPO has advantages and benefits that you can count on, such as a select choice of network hospitals, physicians and specialists.
- You will have access to a broad range of health care benefits, including emergency room care at any hospital, physician office visits and maternity services.
- Prescription drug coverage is offered as an additional benefit option.

* Chicago Metro counties include Cook, Lake, McHenry, Dupage, Kane, Grundy, Kankakee, Kendall and Will. Quad Cities counties include Bureau, Hancock, Henderson, Warren, Whiteside, Henry, Mercer and Rock Island.

Out-of-state coverage

You and your covered dependents have access to health care benefits when traveling out of state under the BlueCard® PPO Program. Blue Cross and Blue Shield (BCBS) Plans throughout the country have established PPO networks of independently contracted doctors, hospitals and other health care providers. Obtain information by calling the Customer Service number on the back of your ID card, or the BlueCard Access telephone number at 800-810-BLUE (2583). All you need to do is show your ID card with the suitcase logo to the doctor or hospital.

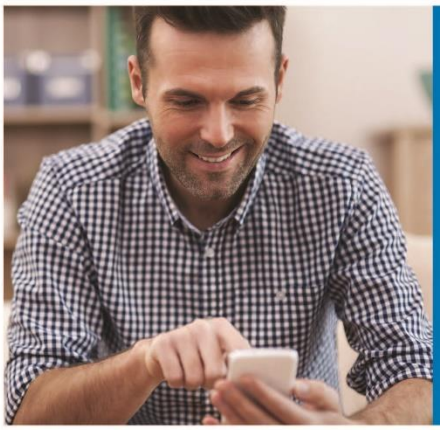
You will be responsible for any applicable copayment or deductible and coinsurance amounts, in addition to any services that are not covered or not approved by BCBSIL.

Get the support and guidance tools needed for informed health care decisions

- Blue Access for Members℠ — a secure, online service where you can:
  - Access confidential claim information, view Explanation of Benefits statements and confirm coverage
  - Search for a contracting physician, hospital or other health care provider
  - Review a hospital's outcome data, based on specific diagnoses and procedures
- BCBSIL's Customer Service team can promptly address your questions and help you understand and use your health care benefits.

Get access to health and wellness programs

- Blue365® Member Discount Program*
  The Blue365 Discount Program offers exclusive health and wellness deals to BCBSIL members, including discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more.
- Health and Wellness Resources**
  Our health and wellness resources provide tools and information, which may help you lose weight, quit smoking or reduce your risk for developing heart disease, stroke or diabetes.



Why Blue Choice Select PPO works

- Access to a defined network of independently contracted providers, including more than 15,000 physicians and over 60 hospitals in the Chicago and Quad Cities service areas
- Access to a full range of participating ancillary services, such as home health care, hospice, private duty nursing, surgery centers and skilled nursing facilities
- Self-directed care
- Health and wellness programs**
- Web and mobile tools

*Blue365 is a discount program only for BCBSIL members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSIL does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSIL reserves the right to stop or change this program at any time without notice.

The relationship between these vendors and BCBSIL is that of independent contractors. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by Blue365 discount program vendors.

**Our health and wellness resources vary by health plans.

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BlueCross BlueShield of Illinois

Your Doctor Is In...Provider Finder®

Spend less time looking for a doctor and more time enjoying your life.

Provider Finder from Blue Cross and Blue Shield of Illinois (BCBSIL) is a fast, easy-to-use tool to find your next health care provider. Plus, it can help you manage health care costs.

Go to **bcbsil.com** and log in or create a Blue Access for Members℠ (BAM℠) account and click on the Doctors and Hospitals tab in Provider Finder to:

- Find in-network providers, hospitals, laboratories and more.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Estimate the out-of-pocket costs of more than 1,600 health care procedures, treatments and tests.*
- Use quality awards such as Blue Distinction® Center (BDC), BDC+ or Total Care to inform your choices.
- See side-by-side provider or facility quality ratings and patient reviews.*

Go Mobile with BCBSIL

At bcbsil.com, log into or create your BAM account. You can stay linked to your claims activity, member ID card and coverage details. It's also where to see prescription refill reminders and health tips by text messages at 33633.

*Available for most networks and plans.

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BlueCross BlueShield of Illinois

Understanding Your Explanation of Benefits

An Explanation of Benefits (EOB) is a notification provided to members when a health care benefits claim is processed by Blue Cross and Blue Shield of Illinois (BCBSIL). The EOB shows how the claim was processed. The EOB is not a bill. Your provider may bill you separately.

THE EOB HAS THREE MAJOR SECTIONS:

- Subscriber Information and Total of Claim(s) includes the member's name, address, member ID number and group name and number. The Total of Claims table shows you the amount billed, any applied discounts, reductions and payments and the amount you may owe the provider.
- Service Detail for each claim includes:
  - Patient and provider information
  - Claim number and when it was processed
  - Service dates and descriptions
  - The amount billed
  - The discounts or other reductions subtracted from amount billed
  - Total amount covered
  - The amount you may owe (your responsibility)
- Summary - Shows you what the plan covers for each claim and your responsibility including:

  Plan Provisions
  - The amount covered
  - Less any amounts you may owe, like deductible, copay and coinsurance

  Your Responsibility
  - Deductible and copay amount
  - Your share of coinsurance
  - Amount not covered, if any
  - Amount you may owe the provider. You may have paid some of this amount, like your copay, at the time you received the service.

THE EOB MAY INCLUDE ADDITIONAL INFORMATION:

- Amounts Not Covered will show what benefit limitations or exclusions apply.
- Out-of-Pocket Expenses will show an amount when a claim applies toward your deductible or counts toward your out-of-pocket expenses.
- Fraud Hotline is a toll-free number to call if you think you are being charged for services you did not receive or if you suspect any fraudulent activity.
- An explanation of your right to appeal if your health plan doesn't cover a health care claim.

Your EOBs Are Available Online!

Sign up for Blue Access for Members℠ (BAM℠) at **bcbsil.com** for convenient and confidential access to your claim information and history. Choose to opt out of receiving EOBs by mail to save time and resources. Go to BAM and click on **Settings/Preferences** to change your preferences.

bcbsil.com

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Contact Information

If you have questions about information covered in this guide, contact your Benefits Specialist.

Certified Staff and Administrators
Michelle Wavering
630.420.6325
mwavering@naperville203.org

Non-Certified Staff
Danette Pietrarosso
630.420.6327
dpietrarosso@naperville203.org

Carrier Contact Information	Phone	Website
Medical Carrier		
BCBSIL Members	1.800.458.6024	https://bcbsil.com/
In-Network Provider Finder		https://www.bcbsil.com/find-a-doctor-or-hospital
Prime Therapeutics – Prescription Drugs	1.800.423.1973	https://www.myprime.com
Utilization Review	Call the number on the back of your ID card	
Dental Carrier		
Delta Dental PPO Members	1.800.323.1743	https://www.deltadentalil.com
Vision Carrier		
Humana Vision Members	1.877.398.2980	https://www.humana.com
Flexible Spending Account		
PayFlex Systems, USA, Inc.	1.844.729.3539	https://www.payflex.com/en/individuals.html
Health Savings Account		
Lively	1.888.576.4837	https://www.livelyme.com
Life Insurance Carrier		
Reliance Standard Life Insurance	1.800.351.7500	https://customercare.rsli.com/
Voluntary Life/Critical Illness/Accident		
Reliance Standard Life Insurance	1.800.351.7500	https://customercare.rsli.com/
Employee Assistance Program (EAP)		
Northwestern Medicine at Central DuPage Hospital	1.888.933.1327	https://www.nm.org/conditions-and-care-areas/behavioral-health/behavioral-health-services-western-suburbs/employee-assistance-program-in-the-western-suburbs
Telemedicine		
Teladoc Medical/Behavioral Health	1.800.835.2362	https://www.teladoc.com/