Open Enrollment Guide: 2022 Plan Year

Open Enrollment: October 27 – November 10, 2021

Your Benefits Will Not Automatically Renew --
Active Enrollment Required!

Have you talked to alex®?

Walk through your options at http://www.myalex.com/districtu46/2022

ALEX® is YOUR personal benefits counselor. Available 24/7.

Picking the right benefit plans can be a challenge.

- Which medical plan is best for me?
- How much should I save in my flexible spending accounts?
- Should I get extra life insurance?
- Does a health savings account make sense for me?

These decisions are important, and a lot goes into making the right choice. To make the process easier for you, School District U-46 has an easy-to-use online tool called ALEX.

All you have to do is log on and respond to ALEX's questions. ALEX will prompt you for some basic information about you and your family, ask a few questions about your personal situation (everything you say remains confidential, of course), and help you figure out what to choose based on your responses.

Talking with ALEX feels like having a conversation with a real person, and because ALEX uses simple language and avoids insurance jargon, his explanations and recommendations are easy to understand. For 2022 Open enrollment, you can also elect an abbreviated version as well as save your responses if you need a break.

ALEX is available from any computer or device with an internet connection. If you have any questions, ALEX can walk you through them.
Start a conversation with ALEX today. Visit https://www.myalex.com/districtu46/2022.

Need Additional Assistance? **Attend an Online Live Open Enrollment Meeting!**	
School District U-46 will be holding online Open Enrollment Meetings via Zoom on the following dates/times:	
Wednesday, October 27, 2021 6:30 P.M. Click here to join.	**Thursday, November 4, 2021** 4:00 P.M. Click here to join.
A RECORDED VERSION OF THESE MEETINGS WILL BE POSTED ON THE BENEFITS HOME PAGE IF YOU ARE UNABLE TO ATTEND A LIVE MEETING	

October 27, 2021

Dear Colleagues,

School District U-46 strives to offer a competitive benefits package to support the health and well-being of its employees and their dependents. We will open enrollment for 2022 benefit plans on October 27 and ask that you submit your elections by November 10, 2021. New enrollments and changes become effective January 1, 2022. Take time to **restart**, **engage** and **manage** options each year so you can **achieve** a healthy lifestyle for you and your family. You will definitely want to consider and compare all four available medical options to see which plan is the best fit for you.

The last year has been very difficult for everyone due to the COVID-19 pandemic, government shutdowns and social distancing. For 2022, employees should **restart** and make their personal health a priority. As a reminder, *the District's Employee Assistance Plan ("EAP") is available to all employees and provide up to 8 free mental health visits*. Also, if you enroll in a medical plan, all preventive care is covered at 100%.

Engage in the process by accessing *ALEX*, a unique, online experience that aims to help you make decisions about your benefit options. "Talking" with ALEX is easy; answer some basic questions about your personal situation (your answers remain anonymous, of course), and ALEX will crunch some numbers and explain your available benefit options — all with a healthy dose of humour. Visit ALEX at https://www.myalex.com/districtu46/2022 if you have questions about your benefit plan options. Find out why 96 percent of District employees who used ALEX last year indicated that they better - understood their medical options.

You can better ***manage*** your health care costs by using a number of solutions. Take advantage of the tax savings offered by Health Savings or Flexible Spending Accounts. Use network doctors rather than out-of-network providers. Use the UHC cost estimator to identify high quality but lower cost options. Utilize your 8 free EAP mental health benefits before you pay with your medical plan. Enroll in the Level2 Plan if you, or a member of your family, has type 2 diabetes to manage your health care costs and move towards remission.

We all would like to ***achieve*** a healthier lifestyle. District U-46 provides many opportunities for employees and their families to reach their health goals. Get a flu shot! Quit smoking! Get an annual physical! Participate in the Real Appeal weight loss program! Use Stride to track your steps and earn gift cards! All are free if you are enrolled in any one of the District's medical options.

During Open Enrollment, all benefits eligible employees **must log into** Munis Self Service to review or make their elections or waive coverage. If you waived coverage for 2021, you will need to waive coverage again for 2022. ***If you do not make an election by November 10th or waive coverage, you (and only you) will be enrolled in the Silver + HSA and the dental plan.***

I encourage you to carefully review and consider the information provided in the 2022 Open Enrollment Guide. Should you have any questions, please contact our Benefits Department at benefits@u-46.org.

Thank you for all you do for our students and families. I wish you and your families the best of health always.

Sincerely,

Tony Sanders
Chief Executive Officer

School District U-46

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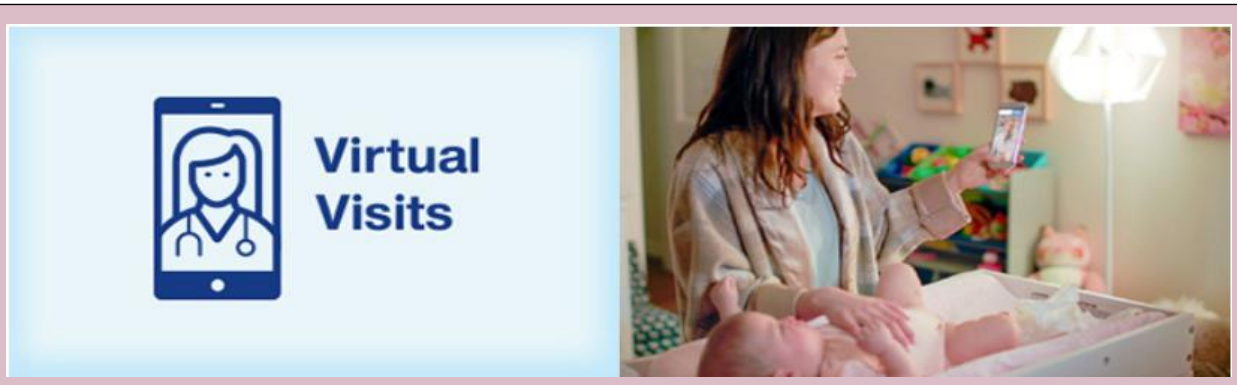


The doctor will see you now. Talk to a doctor, therapist, or medical expert anywhere you are by phone or video.

When you need care – anytime day or night – Virtual Visits can be a great option. From treating colds and fevers to caring for migraines and allergies, you can connect with a doctor whenever, wherever.

- Video chat with a doctor on your mobile device, tablet, or computer.
- Get a prescription if needed
- Pay $50 or less with your District medical plan

When is Open Enrollment?

Open enrollment begins Wednesday, October 27, 2021 and ends at midnight (CST) on Wednesday, November 10, 2021.

What changes can I make?

Open enrollment is your opportunity to elect the following through Munis Self Service: https://selfservice.u-46.org/MSS/

- Medical Plan Options
- Voluntary Critical Illness or Hospital Indemnity Insurance
- Payroll deductions to Health Savings Account if either the Silver + HSA or Gold + HSA is elected
- Dental Plan
- Vision Plan
- Flexible Spending Accounts:
    - Health Care, if the PPO or Level2 Plan is elected
    - Dependent Care
- Supplemental Life Insurance

In addition to the above benefit choices, open enrollment is the time for you to add or subtract dependents to your coverage.

You can only make changes outside of Open Enrollment if you have a qualified life event or family status change (such as marriage, divorce, death, loss of coverage or the birth or adoption of a child). A dependent is (1) your spouse, (2) qualifying child, and/or (3) dependent veteran child. If you have a family status change and you want to make coverage changes, you must contact the Benefits Department within 31 days of the event.

Please Note: The District may periodically review eligibility for dependents. This may include requesting additional documentation from employees.

Do I need to make an election?

All benefit-eligible employees must log in to make elections during this year's **ACTIVE** open enrollment.

- **Continuing Your Current 2021 Election** – If you were enrolled in the Silver + HSA, the Gold + HSA, or the PPO plan last year, and you want to stay in the same plan with the same tier (employee only, employee plus spouse, employee plus children, family), you can click the "No Changes" button next to each section.
- **Waiving Medical Coverage** – You must "actively" waive coverage, or you (and only you) will be enrolled in the Silver + HSA at the employee only coverage level and the dental plan at the employee only coverage level.

Is there a tool to help me choose the right benefit options for me and my family?

The District provides an online benefits counselor – ALEX – to help you choose the right plan for you and your family. ALEX can provide information about the District's benefit program.

ALEX will help you understand your benefits and will email you a personalized benefits summary based on your responses to the questions.

Prior to using ALEX, make a list of how many times you and your family will have office visits, any planned surgeries, and the maintenance prescriptions you use on a regular basis. When using ALEX, be realistic about your use of doctors.

ALEX analyzes the information you provide to help you make an informed decision about you and your family's needs. The benefit option recommended may be different if you want only catastrophic protection – that is protection for a totally unplanned, major operation – vs. protection for reoccurring medical costs.

ALEX is available from any computer or device with an internet connection. Accordingly, you can access ALEX at home so that your family can participate in the decision-making process.

Visit ALEX at https://www.myalex.com/districtu46/2022.

New for 2022, ALEX will have a chat feature, also available in Spanish, where you can ask questions about your benefit options.

Visit ALEX Chat at https://www.myalex.com/districtu46/home.

How do I make open enrollment elections online?

To ensure a fast, convenient, and secure process, all employees must make their election online by visiting Munis Self Service at https://selfservice.u-46.org/MSS/ to:

- View the plans available to you and their associated costs
- Access plan overviews
- Enroll or make changes to your coverage

Review and Update
Your Emergency Contact Information

Please login to Munis Self Service to review and update your emergency contact information for 2022.

How to enroll

Log on to U-46 Benefits Online at https://selfservice.u-46.org/MSS/ and follow these on-screen instructions.

1. Enter your user ID and password.
   a. Your user ID is your 5-digit Employee ID.
   b. If you have not previously logged in to the site or the online enrollment system.

      The first time that you log in to MUNIS Self-Service, you will use your 5-digit employee ID, and your password will be the last 4 digits of your social security number.
   c. After logging in for the first time, you will be required to change your password. The password must be at least 8 digits/characters; you must have at least one number, one symbol, one capital letter and one lowercase letter. Munis uses two-factor authentication to keep your data secure. Click here for instructions on how to reset your password for Munis Self-Service.
   d. Once logged in, click on the "Employee Self Service" link and then select "Benefits." Your current elections will be displayed – click the link that says "You must complete your open enrollment before 11/10/2021" to start the enrollment process., or navigate to the Open Enrollment menu option on the right side of the screen.
2. Make and review your elections. Click the blue link to the right of each election.

Elect or waive medical and dental coverage. If you do not make an election or waive coverage, **you will be enrolled in the Silver + HSA for medical coverage and dental benefits at the single level.**

Eligibility to participate in the program

An individual's eligibility for the health care program is based on either a collective bargaining agreement or a Board resolution. In addition, the Affordable Care Act, also known as Health Care Reform, has specific guidelines to determine eligibility or the District could be subject to significant penalties.

How is eligibility determined for health care benefits?

You are eligible for coverage if you are:

- An employee who is covered by a collective bargaining agreement which provides for you to be offered health care benefits; or
- An employee who is not eligible under a collective bargaining agreement, but who works an average of 30 or more hours per week during the Standard Measurement Period. Any paid hours (holidays, sick leave, personal days) are counted as hours worked.

Eligibility for benefits shall also be subject to the additional requirements, if any, specified in the various benefit plans.

What is the Standard Measurement Period?

The Standard Measurement Period which the District uses is based on pay periods (i.e., October 3 to the following October 2), ending prior to the Plan Year or Stability Period as both terms are defined in the Affordable Care Act.

The District determines hours worked each week during the Standard Measurement Period and divides those hours by 52 to determine the average hours worked during the Standard Measurement Period. (Many hourly employees may not be credited with hours during the District's breaks.)

Union employees. If you are provided coverage pursuant to a collective bargaining agreement, the Standard Measurement Period calculation is not applicable. It is only applicable to those who do not have coverage through the collective bargaining process.

But what happens if I don't work 12 months during the year?

The regulations under the Affordable Care Act established special rules for school districts. If you have a break in service for more than 4 weeks, the District disregards that break in service for the calculation. For example, if you don't work during the Summer, the denominator is usually 41 weeks rather than 52 weeks.

Can you give me some examples of how this works?

Example A: Jane Doe is a non-union hourly employee who normally works 6 hours per day for 5 days a week when school is in session. Jane is in a position where she is not paid for the Spring Break or Winter Break but is paid for holidays not occurring during Winter Break. So, she worked 38 weeks with 30 hours of service each week and 3 weeks with 0 hours, for a total of 1,140 hours. The 1,140 hours are divided by 41 weeks – the period during the Standard Measurement Period during which she had no break in service but disregarding the 11 weeks of Summer Break. Therefore, Jane worked only an average of 27.8 hours per week and is not eligible for benefits the next plan year.

Example B: Same facts as Example A, but Jane worked an extra 90 hours over the 38 weeks when school was in session. So, she had a total of 1,230 hours for an average of 30 hours per week. As a result, Jane is eligible for health care benefits for the next plan year.

Example C: Same facts as Example A, but Jane worked 6.5 hours per day for 5 days a week. So, she worked a total of 1,235 hours for an average of 30.1 hours per week. As a result, Jane is eligible for benefits for the next plan year.

Example D: Same facts as Example C, but Jane was tardy an average of 0.50 hours per week. So, she had worked a total of 1,216 hours for an average of 29.7 hours per week. As a result, Jane is not eligible for benefits for the next plan year.

Just a slight variation in your weekly schedule, due to tardiness or working extra, may affect your eligibility for health care. *Eligibility is based upon your actual hours worked, not the position you hold unless you are covered by a collective bargaining agreement.* So, a person who holds the same position as you may be eligible for benefits and you may not be eligible because your average weekly hours varied.

Medicare Eligible Individuals & HSAs

An individual who is age 65 or older and who is eligible for Medicare can still contribute to an HSA if not enrolled in Medicare.

Individuals who are actually enrolled in Medicare cannot contribute to an HSA. However, any funds in an HSA contributed prior to becoming enrolled in Medicare may still be used for qualified medical expenses.

If you are receiving benefits from Social Security or the Railroad Retirement Board at least 4 months before attaining age 65, you will be automatically enrolled in Medicare Part A and Part B.

See page 16 for more information.

Changes for the 2022 plan year

The District's Health Care Committee, composed of representatives of each collective bargaining unit and the administration, meets regularly to review the operations of the health and welfare benefit programs. As part of their charter, they propose changes to the various programs each year.

The Medical Program

New Medical Plan Option – Level2 Plan *(for type 2 diabetics)*

The District will offer the Level2 Plan as a new medical plan option for individuals with type 2 diabetes and their families.

Level2 is a new medical plan that offers personalized and data-driven care for individuals with type 2 diabetes. Through an individualized approach, guided by wearable technologies and personal coaching, Level2 focuses on the reduction of glucose or blood sugar, increasing the time in range of blood glucose levels, and the possibility of type 2 diabetes remission.

See the next page for more details.

Silver, Gold, and PPO Plans

The Silver, Gold, and PPO plans will provide the following expanded breast cancer screenings:

- **MRI breast cancer screenings for individuals at high risk of breast cancer will be covered as preventive care –** MRI breast cancer screenings for individuals at high risk of breast cancer will be covered at 100%.
- **Ultrasound breast cancer screenings for individuals with dense breast tissue will be covered as preventive care -** Ultrasound breast cancer screenings for individuals with dense breast tissue will be covered at 100%.

PPO Plan – No additional changes were made for 2022.

Gold + HSA Plan – No additional changes were made for 2022.

Silver + HSA Plan – No additional changes were made for 2022.

The Pharmacy Program *(for those enrolled in the Silver, Gold, or PPO Plan)*

Implementing the Variable Copay Program – The Variable Copay Program will be added to assist members with high-cost specialty drugs. Certain pharmaceutical manufacturers offer coupons to lower drug costs.

Under the Variable Copay Program:

1. If you order a specialty drug that is included under the Variable Copay Program, UnitedHealthcare will ask you to register for the drug manufacturer's coupon.
2. Your copay will be adjusted to utilize the full dollar value of the available coupon. Your out-of-pocket costs will not change under this program.
3. The value of the coupon will not apply to your deductible or out-of-pocket maximum.

View the listing of drugs under the Variable Copay Program here.

Eliminating 90-day supplies for specialty drugs – All specialty drugs will be limited to a 30-day supply.

The Wellness Program *(for those enrolled in the Silver, Gold, or PPO Plan)*

Adding Kaia as a new optional activity to the wellness program – Employees who "Complete 30 workouts in Kaia" will receive 30% towards their wellness incentive.

Kaia is the smart phone app for physical therapy that helps you fight pain, like back, shoulder, and neck pain, in as little as 15 minutes per day. Kaia creates your own personalized physical therapy program on your mobile phone, using scientific gold-standard techniques that are proven to reduce pain without medication or therapy. The District's medical program covers all costs.

Begin your journey in Kaia at http://startkaia.com/u46.

Decrease A1c and total cholesterol levels – The diabetes A1c and total cholesterol thresholds to earn 20% under the wellness program will decrease to 6.3 for A1c and 210 for total cholesterol.

Voluntary Additional Medical Coverage

(for those eligible to enroll in a medical option)

Critical Illness Program – Starting on January 1,2022, The Standard will replace Reliance as the new provider for the Critical Illness Program. See page 14 for more details.

Hospital Indemnity Program – Starting on January 1,2022, The Standard will replace Reliance as the new provider for the Hospital Indemnity Program. See page 15 for more details.

Introducing the Level2 Plan!

Effective January 1, 2022, the District will offer the Level2 Plan, a new medical plan option that offers personalized and data-driven care for individuals and their families with type 2 diabetes**.**

What is the Level2 Plan?

The Level2 Plan combines real-time data with coaching and support to help members put their type 2 diabetes into remission. Learn more about the Level2 Plan at https://mylevel2.com/u46.

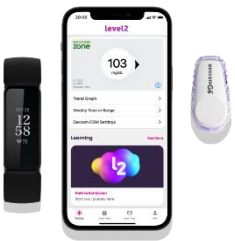
Eligibility

Individuals who are eligible for the District's medical program, who have been diagnosed with type 2 diabetes, or have an eligible spouse or dependent with type 2 diabetes, are eligible to enroll in the Level2 Plan. (Type 1 diabetics are not eligible for the Level2 Plan) *If only one family member has type 2 diabetes, the entire family is enrolled.* Those with a type 2 diagnosis are eligible for the specialty type 2 care under the Level2 Plan, and the rest of the family has coverage similar to a traditional plan. Enrollment in the Level2 Plan is easy.

1. **Choose Level2** – Select the Level2 Plan during open enrollment and pre-register for Level2 specialty care.
2. **Eligibility Confirmed** – United Healthcare will confirm you and/or your spouse are eligible for the plan.
3. **Sign-up for Care** – You and/or your spouse finish registering for Level2 specialty care and download the Level2 app.
4. **Activate Continuous Glucose Monitor ("CGM")** – You will receive a welcome kit including the CGM. With Level2's support, you will get it up and running.
5. **Wear your CGM for 20 days in a calendar quarter** – that's only 20 days in 3 months.
6. **Receive Enhanced Plan Benefits** – Congrats! You just met your goal to received enhanced plan benefits for the next quarter.

Wearable Technology

A Continuous Glucose Monitor and Fitbit are free with Level2. By tracking your glucose levels hundreds of times a day, you see in real time how food, sleep, and movement affect your body, without fingersticks, guesswork, or frequent doctor visits. Just tap the Level2 app to learn what works.



Enhanced Plan Benefits

Members who enroll in the Level2 Plan will receive the following enhanced benefits specifically for their type 2 diabetes care for ***no cost*** if the diabetic family member wears his or her CGM for at least 20 days each quarter:

- Continuous Glucose Monitor
- Diabetes drugs
- Level2 virtual care visits
- Primary care visits
- Diabetes lab tests
- Labs/diagnostics

A Personalized Experience

Medication optimization – Overseeing physicians can reduce or eliminate medications on a member by member basis.

Microinterventions – Coaches help members take small, easy steps that generate big wins in improving diet, activity, and wellbeing.

Machine learning algorithms – Data scientists analyze claims, Rx and individual health record data to drive individualized care.

Real-time tracking & insights – The Dexcom G6 CGM & Fitbit Versa Lite enable personal insights and self-discovery.

Personal support – Through personal intervention, coaches and specialists help customize a plan based on member needs and goals.

Mid-Year 2022 Retirees Ineligible for Level2

Retirees are ineligible to participate in the Level2 Plan. As a result, mid-year 2022 retirees, who elected the Level2 Plan, may move to the Silver, Gold, and PPO Plans.

Re-Introducing Kaia (Physical Therapy for Musculoskeletal Conditions)

Effective January 1, 2021, the District began offering Kaia, a digital, multimodal program to safely and effectively help both the body and brain cope with musculoskeletal conditions. **Kaia is available to members enrolled in either the Silver, Gold, or PPO Plans. Level2 Plan participants are not eligible for Kaia.**

What is Kaia? A Virtual Physical Therapy Provider

Kaia is a digital physical therapy app that is based on the evidence-based concept of multidisciplinary rehabilitation. This means that Kaia delivers content, renewed daily, that is intended to teach users to self-manage their pain.

Kaia is the smart app that helps you fight pain, like back, shoulder, and neck pain, in as little as 15 minutes per day – weather you're already at the office, or you're about to go to bed. Kaia creates your own personalized program on your mobile phone, using scientific gold-standard techniques that are proven to reduce pain without medication or therapy.

Plus, you won't be paying out of pocket – **the District's medical plan covers all costs.** That means no copays or out of pocket costs! And no appointments needed.

Kaia's digital solution provides affordable best-in-class chronic pain management therapy

Comprehensive back pain education - Relevant information in concise modules to boost self-efficacy

Customized daily training sessions - 15 minutes of daily exercises using motion coach

Mindfulness and stress relief - Tailored mindfulness and relaxation exercises

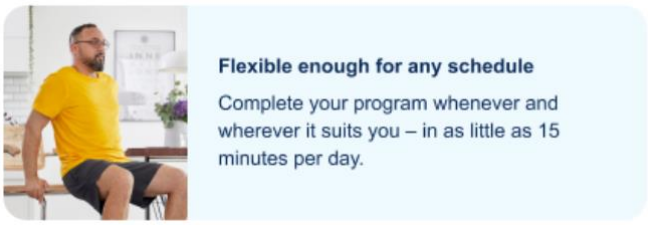
Access to Kaia's certified coaches - Dedicated accredited coaches support you every step of the way through one-on-one Coaching Sessions over the phone or using Kaia Chat

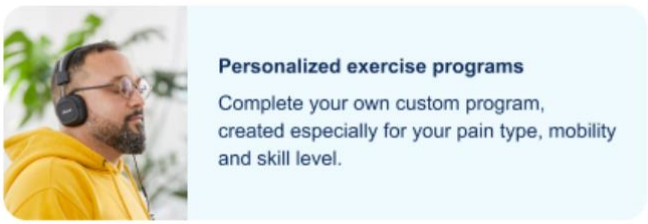
Holistic back pain education

Daily training sessions

Anxiety and stress relief

Support from certified health coaches





How to Enroll in Kaia

If you are enrolled in either the Silver, Gold, or PPO plan, visit http://startkaia.com/u46 to enroll in Kaia and begin your virtual physical therapy.

2022 Medical Plan Options

District U-46 offers three medical options which are self-funded medical programs [Silver, Gold, and PPO Plans]. The risk of providing the medical benefits under the District's Employee Health Care Benefits Program is borne by the District and not by an insurance company (except for claims over $600,000 per individual, which are insured). Beginning in 2022, the District will also offer a fourth plan [Level2], a fully-insured plan for employees, and their family members, with type 2 diabetes. All four plans are administered by UnitedHealthcare on behalf of the District

The four medical options being offered are:

1. **Silver + HSA –** This plan is a PPO Plan with a Health Savings Account (HSA). Participants will receive a District contribution to their HSA. **These employer contributions are deposited in late January 2022.** In order to receive the contributions, the employee must be an active employee of the District and currently enrolled in this plan on the date the District contribution is made. Employees may contribute more to their HSAs through payroll deduction or directly to Optum Bank.
2. **Gold + HSA –** Participants will receive a District contribution to their HSA. The rules for HSAs as described above for the Silver + HSA also apply for the Gold + HSA.
3. **PPO Plan –** This plan is a PPO plan which, after a participant meets the deductible, provides copays for office visits and pharmacy coverage, and coinsurance for services outside of the physician's office, emergency room, urgent care, and in-patient services. The first 3 visits per certain service categories – telemedicine, primary care provider, and specialist – will be covered at the applicable copay before the deductible has been met. **This plan is only available to employees who have completed two years of service with the District prior to January 1, 2022.**
4. **Level2 Plan –** School District U-46 will be offering the Level2 Plan starting January 1, 2022. Level2 offers personalized and data-driven care for individuals with Type 2 diabetes and their families. Members receive the following benefits for no cost if they wear their CGM (Continuous Glucose Monitor) device for at least 20 days each quarter: CGM, diabetes drugs, Level2 virtual care team visits, primary care visits, diabetic supplies, and diabetes lab tests**. (The Level2 Plan does not provide out-of-network benefits.)**

The **Silver, Gold, PPO and Level2 Plans** offer the same services and benefits. The difference among the plans relate to the cost-sharing – deductibles, coinsurance, and copays.

- All Silver, Gold, and PPO Plans offer the same network (Choice Plus) of providers. The Level2 plan offers the Choice network that does not include out-of-network providers.
- The Silver, Gold, and PPO Plans have a three-tiered network which includes: 1) premium designated "in-network" providers, 2) non-premium designated in-network providers, and 3) out-of-network providers. The Level2 Plan only includes in-network providers.
- The Silver, Gold, and PPO Plans have a **calendar-year deductible**, which must be met before the plan option will pay for any benefits (with the exception of certain preventive prescriptions under the Gold + HSA and Silver + HSA plans and telemedicine, primary care provider, and specialist visits under the PPO Plan).
- The Silver, Gold, and PPO Plans have an **embedded calendar year deductible** which is a system that combines individual and family deductibles in a family health benefit plan. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible before after-deductible benefits kick in.
- Each plan has a **maximum out-of-pocket limit**, which is the maximum amount you will pay. Once you reach the maximum out-of-pocket limit, the plan will pay 100% of any remaining health care costs for the calendar year.
- The Silver, Gold, and PPO Plans an **embedded maximum out-of-pocket limit** which means that no individual can be required to pay more in annual cost sharing than the self-only out-of-pocket limit, even under a family coverage plan that is subject to a higher overall out-of-pocket maximum.

The chart on the next page describes, in general, the cost sharing differences among the first three medical options. Specific cost sharing is described in the summary plan description for the medical options.

Which Plan has the highest benefit level?

2022 Health Plan	Benefit Level Percentage	Plan Coverage Level on Federal Marketplace
Gold + HSA	84%	Gold Level Plan
Silver + HSA	80%	Silver/Gold Level Plan
PPO Plan	80%	Silver/Gold Level Plan

Medical Plan Summary of Benefit Coverage *(What the Participant Pays)*

Plan Features[1]	Silver + HSA Plan		Gold + HSA Plan		PPO Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
District's HSA Contribution						
Individual Coverage	$480		$600		N/A	
Family Coverage (any level of dependent coverage)	$960		$1,200		N/A	
Calendar Year Deductible						
Individual Deductible	$2,000	$4,000	$1,500	$3,000	$750	$1,500
Family Deductible	$4,000	$8,000	$3,000	$6,000	$2,150	$4,300
Embedded Deductible	$2,800	$5,600	$2,800	$5,600	$750	$1,500
Max. Out-of-Pocket Limit						
Individual	$4,000	$8,000	$3,000	$6,000	$4,750	$9,500
Family	$8,000	$16,000	$6,000	$12,000	$9,500	$19,000
Embedded	$4,000	$8,000	$3,000	$6,000	$4,750	$9,500
Wellness Benefits						
Routine Physical Exams	0%	50% after deductible	0%	50% after deductible	0%	50% after deductible
Physician Services						
Virtual Office Visit (Telemedicine)	10% after deductible	n/a	20% after deductible	n/a	$10 visit copay after deductible[2]	n/a
Office Visits to Primary Care Physician	10% after deductible	50% after deductible	20% after deductible	50% after deductible	$30 visit copay after deductible[2]	50% after deductible
Physical Therapy, Occupational Therapy, Speech Therapy Visits	10% after deductible	50% after deductible	20% after deductible	50% after deductible	$30 visit copay after deductible	50% after deductible
Specialist Office Visits (Premium/Non-Premium)	20%/30% after deductible	50% after deductible	10%/20% after deductible	50% after deductible	$40/$50 visit copay after deductible[2]	50% after deductible

[1] This chart represents a summary of features of each plan design. There may be certain restrictions, such as pre-authorization notices, required use of network providers, visit limitations, etc., that may apply to certain coverages. Those restrictions are applicable to all of the medical options. If there is any discrepancy between this chart and the plan document, the plan document requirements shall prevail. For more information, please consult the summary plan description.

[2] The deductible will not apply to the first three visits per member. The applicable co-pay will apply.

If you have any questions, contact the District's Benefits Department by calling 847.888.5000 or email Benefits @U-46.org

Plan Features[1]	Silver + HSA Plan		Gold + HSA Plan		PPO Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Physician Services for Inpatient Facility and Hospital Visits (Premium/Non-Premium)	20%/30% after deductible	50% after deductible	10%/20% after deductible	50% after deductible	10%/20% after deductible	50% after deductible
Emergency Services						
Emergency/Non-Emergency Care in a Hospital Emergency Room	30% after deductible		20% after deductible		20% after deductible	
Urgent Care Services						
Urgent Medical Care (at a non-hospital free-standing facility)	30% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery, Diagnostic and Preoperative Testing	30% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Facility Expenses						
Hospital Facility Expenses	30% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible

Pharmacy Benefit[3] (network only)[4] (after deductible)[5] [6]	$ or %	Min	Max	$ or %	Min	Max	$ or %	Min	Max
30-day Retail									
• **Tier 1 – Generally Generic**	$5			$10			$10		
• **Tier 2 – Preferred Brand**	$20			$35			$30		
• **Tier 3 – Non-Preferred Brand**	50%	$50	$150	50%	$75	$200	50%	$50	$150
• **Tier 4 – Specialty**	30%	$75	$150	30%	$35	$50	30%	$75	$150
90-day Mail Order or Retail									
• **Tier 1 – Generally Generic**	$10			$25			$25		
• **Tier 2 – Preferred Brand**	$50			$85			$75		
• **Tier 3 – Non-Preferred Brand**	50%	$125	$375	50%	$185	$500	50%	$125	$375
• **Tier 4 – Specialty**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[3] Not all prescriptions are covered. For a list of exclusions, click here.

[4] Only those retail prescriptions obtained from pharmacies in UnitedHealthcare's Walgreens Anchored Network are covered under the Plan. For a list of Walgreens Anchored Network pharmacies, go to myUHC.com.

[5] Participants will pay the above pharmacy copayments or coinsurance only after meeting the plan's deductible. Participants in the Silver + HSA Plan or Gold + HSA Plan have a preventive medications feature that provides coverage for the medications you need without first meeting your deductible. That means that you can get certain preventive medications at separate copay levels based on the medication's tier. For a list of preventive medications that meet the federal guidelines, click here.

[6] Drug manufacturer coupons or copay cards do not count towards the plan's deductible or out-of-pocket maximum.

If you have any questions, contact the District's Benefits Department by calling 847.888.5000 or email Benefits @U-46.org

Contributions for Employees

Coverage Tier by Plan	Annual Cost			Employee Contribution Per Deduction	
	Annual Premium	District Portion	Employee Portion	26 Pay Periods	21 Pay Periods
Silver + HSA					
Employee only	$5,122	$4,354	$768	$29.54	$40.42
Employee plus spouse	$10,501	$8,926	$1,575	$60.58	$82.89
Employee plus children	$8,811	$7,489	$1,322	$50.85	$69.58
Family	$14,599	$12,409	$2,190	$84.23	$115.26
Dependent Veteran Child	$5,122	$0	$5,122	$197.02	$269.60
Gold + HSA					
Employee only	$10,644	$9,047	$1,597	$61.42	$84.05
Employee plus spouse	$21,819	$18,546	$3,273	$125.88	$172.26
Employee plus children	$18,307	$15,561	$2,746	$105.62	$144.53
Family	$30,334	$25,784	$4,550	$175.00	$239.47
Dependent Veteran Child	$10,644	$0	$10,644	$409.37	$560.19
PPO Plan					
Employee only	$9,005	$7,654	$1,351	$51.96	$71.11
Employee plus spouse	$18,459	$15,690	$2,769	$106.50	$145.74
Employee plus children	$15,488	$13,165	$2,323	$89.35	$122.26
Family	$25,663	$21,814	$3,849	$148.04	$202.58
Dependent Veteran Child	$9,005	$0	$9,005	$346.33	$473.92
Level2 Plan					
Employee only	$13,142	$11,171	$1,971	$75.81	$103.74
Employee plus spouse	$26,941	$22,900	$4,041	$155.42	$212.68
Employee plus children	$22,604	$19,213	$3,391	$130.42	$178.47
Family	$37,455	$31,837	$5,618	$216.08	$295.698
Dependent Veteran Child	$13,142	$0	$13,142	$505.46	$691.68

Level2 Plan Design *(compared to the District's PPO plan)*

	PPO Plan	Level2 Standard Benefits	Level2 Enhanced Benefits*	Level2 Out of Network Benefits
Medical Benefits				
Deductible (Single/Family)	$750/$2,150	$2,000/$4,000	$2,000/$4,000	Level2 Plans do not provide out-of-network benefits
Max. Out-of-Pocket Limit (Single/Family)	$4,750/$9,500	$4,250/$8,500	$4,250/$8,500	
Preventative Care	0%	$0	$0	
Virtual Visits	$10	$0 via Healthiest You	$0 via Healthiest You	
Primary Care Physician	$30	$25: Designated Network $50: Network + no deductible	**$0: Designated Network** $50: Network + no deductible	
Specialist Office Visit	$40/$50	$50: Designated Network $100: Network + no deductible	$50: Designated Network $100: Network + no deductible	
PT/OT/ST	$30	$50: Designated Network + no deductible	$50: Designated Network + no deductible	
Chiropractic	$30	$30	$30	
Urgent Care	20%	$75: Designated Network + no deductible	$75: Designated Network + no deductible	
Outpatient Care				
Labs/Diagnostics	20%	$50: Physician $50: Freestanding Facility $100: Outpatient Hospital + no deductible	**$0: Physician** **$0: Freestanding Facility** **$0: Outpatient Hospital** + no deductible	Level2 Plans do not provide out-of-network benefits
Imaging	20%	0%: Physician $250: Freestanding Facility $500: Outpatient Hospital	0%: Physician $250: Freestanding Facility $500: Outpatient Hospital	
Outpatient Surgery	20%	$300: Freestanding Facility $700: Outpatient Hospital	$300: Freestanding Facility $700: Outpatient Hospital	
Emergency Department	20%	0%: ER Physician $300: Facility	0%: ER Physician $300: Facility	
Inpatient Care				
Inpatient Hospital	20%	0%: Physician $400: Facility Admit	0%: Physician $400: Facility Admit	Level2 Plans do not provide out-of-network benefits
Skilled Nursing Facility	20%	$250: Facility	$250: Facility	
Other				
DME (including diabetic supplies)	20%	$50	**$0 Diabetic Supplies** $50	Level2 Plans do not provide out-of-network benefits
Home Health	$30	$100	$100	
Ambulance	0% (20% non-emergency)	$250	$250	

	PPO Plan In-Network		Level2 Standard Benefits		Level2 Enhanced Benefits*		Level2 Plan Out-of-Network Provider
Pharmacy Benefits	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**	
Tier 1	$10	$25	$6 + no deductible	$15 + no deductible	**$0 diabetic drugs** $6 + no deductible	**$0 diabetic drugs** $15 + no deductible	Level2 Plans do not provide out-of-network benefits
Tier 2	$30	$75	$40 + no deductible	$100 + no deductible	**$0 diabetic drugs** $40 + no deductible	**$0 diabetic drugs** $100 + no deductible	
Tier 3	50%	50%	50% + no deductible	50% + no deductible	**$0 diabetic drugs** 50% + no deductible	**$0 diabetic drugs** 50% + no deductible	
Tier 4	30%	N/A	N/A	N/A	N/A	N/A	

*Level2 Enhanced Benefits *(if the diabetic member wears their Continuous Glucose Monitor for at least 20 days each quarter)*

Level2 Plan Members will receive the following benefits specifically for their type 2 diabetes care for ***no cost*** if the diabetic family member wears his or her Continuous Glucose Monitor for at least 20 days each quarter:

- Continuous Glucose Monitor
- Diabetes drugs
- Level2 virtual care team visits
- Primary care visits
- Diabetic supplies
- Diabetes lab tests

These benefits would cost, on average, ***up to $2,000 to $3,000 annually*** for type 2 diabetics under the District's other plan offerings.

Introducing The Standard

Starting on January 1,2022, The Standard will be the District's new provider for supplemental life, critical illness, and hospital indemnity insurance.

The Standard Insurance Company, also branded as The Standard, is an American insurance and financial company. Standard Insurance Company has maintained an "A" rating or higher from A.M. Best Company since 1928 with assets $41.12 billion (December 31, 2020) and more than 3,100 employees.

It's easy to elect or increase your coverage during this one-time open enrollment period, October 27 – November 10, 2021

As the new provider for these voluntary plans, the benefits and coverage are very similar to the existing coverage with the current carrier, Reliance. The District has made every attempt to match the existing benefits and coverage, but there are some differences such as rates, coverage levels, etc.

For supplemental life insurance, you may elect up to $250,000 in coverage, but not to exceed 2 times your annual earnings in supplemental life insurance, or increase your supplemental life insurance up to $250,000, but not to exceed 2 times your annual earnings, without answering medical underwriting questions. After this special enrollment period, medical underwriting approval may be required.

During the 2022 open enrollment, you will need to select these voluntary benefits for the 2022 calendar year.

Do you have enough Life Insurance to help take care of the people you love?

The District provides a basic amount of life insurance that pays your loved ones a benefit if you pass away. But will that be enough?

Think about the people who share your life and all the expenses they will face. By purchasing additional Life Insurance now, you can help take care of their needs and protect their future.

Do you need Critical Illinois Insurance?

You can prepare for the unexpected costs of a serious illness that are not covered by medical insurance. Critical Illness insurance provides cash to participants diagnosed with a serious illness. Participants can use the money for whatever they need during treatment or recovery, such as medical expenses, like copays and deductibles, and living expenses.

Do you need Hospital Indemnity Insurance?

Employees prepare for the unexpected costs that can come with a hospital stay. Being in the hospital may result in expenses not covered by medical insurance. Hospital Indemnity insurance pays cash benefits to participants who've been hospitalized. Participants can use the money for whatever they need during treatment or recovery. They can pay for medical expenses like copays and deductibles or living expenses.

Voluntary Critical Illness Insurance

Starting on January 1, 2022, The Standard will be the new provider for Voluntary Critical Illness Program. Voluntary critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare. This plan is not considered other health insurance for eligibility purposes of health savings accounts. Watch an informational video here.

Eligibility

An employee and dependents who are eligible to participate in one of the District's base medical options are eligible to elect this voluntary insurance coverage. You do not need to enroll in one of the District's base medical options in order to elect Critical Illness Insurance. The employee must elect critical illness coverage in order for a dependent to have coverage. A person may not have coverage as both an employee and as a dependent.

Benefit Amount

- Employee – Choose from a minimum $10,000 to a maximum of $30,000 in $10,000 increments
- Spouse – Choose from a minimum $10,000 to a maximum of $30,000 in $10,000 increments
- Dependent child(ren) – 25% of approved employee amount up to a maximum of $7,500
- Recurrence Benefit (same illness) – 100% if diagnosed 6 months or later
- Pre-Existing Condition Limitation – None
- Exclusions – Certain exclusions may apply. See Certificate of Insurance for a full list.

Guaranteed Issue

- Employee – $30,000
- Spouse – $30,000
- Child – 50% of the Employee Amount

Features

Adult Diagnosis	Benefit
Cancer	100%
Carcinoma in Situ	25%
End -stage Renal (Kidney Failure)	100%
Major Organ Failure	100%
Severe Coronary Artery with Suggested Bypass	25%
Stroke	100%
Coma	100%
Paralysis	100%
Loss of Hearing, Sight, or Speech	100%
Occupational Hepatitis	100%
Occupational HIV	100%
Advanced Alzheimer's Disease	100%
Advanced Multiple Sclerosis	100%
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis	100%
Benign Brain Tumor	100%
Bone Marrow Transplant	100%
Child Diagnosis	**Benefit**
21 Childhood Diseases* see below for more details	100%

***Covered Child critical illness**: Anal Atresia, Anencephaly, Biliary Atresia, Cerebral Palsy, Cleft Lip or Cleft Palate, Club Foot, Coarctation of the Aorta, Cystic Fibrosis, Diaphragmatic Hernia, Down's Syndrome, Gastroschisis, Hirschsprung's Disease, Hypoplastic Left Heart Syndrome, Infantile Hypertrophic Pyloric Stenosis, Muscular Dystrophy, Omphalocele, Patent Ductus Arteriosis, Spina Bifida Cystica with Myelomeningocele, Tetralogy of Fallot, Transposition of the Great Arteries.

Premium: Monthly Rate per $10,000 Coverage

	Age Band	Premium Rate
Employee and Spouse	0-29	$2.10
• Age at last birthday as of January 1st	30-39	$3.60
• Spouse age is the same as employee when determining premium	40-49	$8.00
	50-59	$17.50
	60-69	$33.00
• This rate includes Child coverage	70+	$58.50

This plan summary is a brief description of the key features of the Standard's Voluntary Critical Illness Program. It is not a certificate of insurance or evidence of coverage.

Voluntary Hospital Indemnity Insurance

Coverage

Starting on January 1,2022, The Standard will be the new provider for the Hospital Indemnity Insurance Plan. Voluntary Hospital Indemnity Insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment. Watch an informational video here.

Eligibility

An employee and dependents who are eligible to participate in one of the District's base medical options are eligible to elect this voluntary insurance coverage. You do not need to enroll in one of the District's base medical options in order to elect Hospital Indemnity Insurance The employee must elect hospital indemnity coverage in order for a dependent to have coverage. A person may not have coverage as both an employee and as a dependent.

Benefits

Benefit	Limit	Amount
Hospital Room & Board Benefits	Per Day Benefit *(up to 15 Daily Benefits Per Plan Year)*	$100
Hospital Critical Care Benefits *(Paid in addition to Room & Board Benefit)*	CCU Benefits Per Day *(up to 15 Daily Benefits Per Plan Year)*	$100
Hospital Admission Benefit	One Daily Benefit Per Plan Year	$500
Critical Care Admission Benefit	One Daily Benefit Per Plan Year	$500
Health Maintenance Screening Benefit	Per Day Benefit	$50

Features`

- Reinstatement
- Continuity of Coverage
- Waiver of Premium
- Continuation of Insurance (Portability) for the member

Exclusions

Benefits will not be paid for any injury or sickness caused by: war or act of war, attempted suicide or self- inflicted injury, assault/felony, voluntary use of drug or alcohol in excess of legal limit, travel or flight in or on any aircraft except: traveling as a fare- paying passenger on a regularly scheduled commercial flight or as a passenger on a business trip, dental care or dental procedures – unless treatment is the result of an injury, routine newborn nursing or well-baby care, hospital confinement of a newborn child following the child's birth unless the confinement is as a result of an injury or sickness, riding in or driving any automobile in a race, stunt show, or speed test, surgery or other procedure which is directed at improving your or your dependent's appearance, unless such surgery or procedure is necessary to correct a deformity or to restore bodily function resulting from an Injury or sickness, any injury or sickness which occurs while you or your dependents are incarcerated in a jail, penal or correctional institution.

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

Claims Example: Brooke's Childbirth

- Brooke delivered via C-Section which required a three-day hospital stay.
- Her Hospital Indemnity coverage paid a benefit check directly to her.
- She chose how to spend the money – to help with medical copays or expenses like meal delivery and diapers.

Claims Example: Brooke's Benefits	Amount
Admission	$500
Daily Hospital ($100 x 3)	$300
Critical Care Admission	$500
Critical Care Confinement ($100 x 3)	$300
Total Benefit of Childbirth	**$1,600**

Premiums

Coverage Level	Monthly Premium
Employee Only	$ 7.44
Employee plus Spouse	$12.80
Employee plus Children	$10.70
Employee plus Family	$18.88

This plan summary is a brief description of the key features of The Standard's Hospital Indemnity Program. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage.

Health Savings Accounts

What is a Health Savings Account (HSA)?

An HSA is a personal bank savings account that you own that offers significant tax savings if you use the funds for eligible medical expenses. Your contributions to an HSA are not subject to any federal or Illinois income or employment taxes, the interest you earn on the account is tax-free, and any withdrawals used for eligible medical expenses are tax-free. Withdrawals for *other than eligible medical expenses* are subject to income tax and a penalty if withdrawn before age 65.

Who is eligible for an HSA?

If you are an active employee in the Silver + HSA or Gold + HSA and are otherwise eligible according to federal law, you are eligible for the District's HSA.

Federal law states that a person is eligible for an HSA if, with respect to any month:

1) Is covered under a high deductible health plan (HDHP) (which the Silver + HSA and the Gold + HSA plans are) as of the first day of the month; and
2) While covered under an HDHP plan, is not covered under any health plan:
   a) That is not a high deductible health plan, and
   b) That provides coverage for any benefit that is covered under the HDHP plan which he/she is enrolled.

How much can I contribute to an HSA?

Federal law limits the amount one can contribute to an HSA. Although the limit is stated on an annualized basis, the actual limit is pro-rated based on the number of months enrolled in a HDHP.

The below chart describes the annual limit for 2022:

	Silver + HSA	Gold + HSA
Single Coverage		
Legal Contribution Maximum*	$3,650	$3,650
District Contribution**	$480	$600
Your Contribution Maximum	**$3,170**	**$3,050**
Family Coverage		
Legal Contribution Maximum*	$7,300	$7,300
District Contribution	$960	$1,200
Your Contribution Maximum	**$6,340**	**$6,100**

**Individuals 55 and older are also eligible for a $1,000 catch-up contribution*
***You must be an active employee at the time the District contribution is made.*

You can elect to make your own personal contributions through convenient payroll deductions. If you contribute to a 403(b) or 457 program, you may want to consider contributing the maximum to your HSA first as an HSA offers significant tax savings and can be invested once you accumulate sufficient funds.

How does Medicare affect HSA eligibility?

Medicare is not a "high deductible health plan" and, therefore, **if you are enrolled in Medicare, you cannot contribute to an HSA**. However, an individual who is age 65 or older and who is *eligible for Medicare* can still contribute to an HSA if *not enrolled in Medicare*.

Automatic Medicare Enrollment In Certain Instances. If you are receiving benefits from Social Security or the Railroad Retirement Board at least 4 months before attaining age 65, you will be automatically enrolled in Medicare Part A and Part B.

Actively Employed At Age 65. If you or your spouse is still working AND have health care coverage from you or your spouse's employer or union, you do not have to sign up for Medicare Part A or Part B until 8 months beginning the month after the employer or union coverage ends or when the employment ends (whichever is first). If you enroll in Medicare Part A and Part B during that special enrollment period, then no Medicare enrollment penalty would apply.

Please note that you must be actually enrolled in Medicare to not be eligible to contribute to an HSA. If you are eligible *(and not enrolled)*, then you can still contribute to an HSA.

If you have questions about whether you are enrolled in Medicare, please contact the Centers for Medicare and Medicaid Services within the Federal Department of Health and Human Services.

For more information, click here.

How can I use my HSA?

You can decide how and when to use these funds. You can either use them to pay for current health care expenses or save them for future needs. HSA account balances can be used for yourself, your spouse and/or dependent children.

*[**Please note**: If you have a non-dependent child under age 27 enrolled as a Qualifying Child in the health plan, out-of-pocket expenses related to that non-dependent Qualifying Child are not eligible for reimbursement from your HSA in accordance with federal law.]*

Any amounts that are used for expenses not considered qualified medical expenses are subject to a 20% tax penalty if withdrawn before you attain age 65.

If you die with a balance remaining in your HSA, the account can be used by your spouse as if it were his/her own. If you are not married, the HSA will pass on to your beneficiary and be subject to applicable taxes.

What are HSA qualified medical expenses?

Most medical care and services, dental, vision care, and prescription drugs are considered qualified medical expenses. HSA distributions used to pay insurance premiums will not be tax-free unless they are used for COBRA or USERRA coverage, qualified long-term care insurance, health insurance maintained while you are receiving unemployment compensation, or health insurance for you after age 65 (other than a Medicare supplemental policy).

The Internal Revenue Service (IRS) decides which expenses can be paid from an HSA, which also include, but are not limited to, deductibles, copayments, and medications. The IRS can modify the list at any time. See the chart below for some expenses that are eligible for purchase/reimbursement using an HSA. Please note that this is not a complete list.

Are any COVID-19 expenses eligible?

In 2021, the IRS announced that 1) home testing for COVID-19 and 2) personal protective equipment (PPE) such as masks, hand sanitizer and sanitizing wipes that are purchased "for the primary purpose of preventing the spread of COVID-19" are qualified medical expenses under Section 213(d) of the Code.

Examples of Qualified Medical Expenses

- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examinations
- Artificial limbs
- Artificial teeth
- Bandages
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery (non-cosmetic)
- Car (specially equipped for use by a person with a disability)
- Chiropractor
- Christian Science practitioner
- Contact lenses and solutions
- Crutches
- Dental treatments including x-rays, cleanings, fillings
- Diagnostic devices
- Disabled dependent care expenses
- Doctor's office visits and procedures
- Drug addiction treatment
- Drug prescriptions
- Eyeglasses, eye surgery, and vision examinations
- Fertility treatment
- Guide dog or other service animals
- Health insurance premiums for COBRA plans, long-term care insurance, and health continuation insurance while receiving unemployment benefits
- Hearing aids and batteries
- Home care
- Home improvements made to accommodate a person with a disability
- Hospital services
- Intellectually and developmentally disabled, special home costs for
- Laboratory fees
- Lead-based paint removal
- Learning disability costs
- Legal fees for qualified long-term care services (limited)
- Over-the-counter drugs and items if prescribed by doctor
- Physical therapy
- Psychiatric care if the expense is for mental health care provided by a psychiatrist, psychologist, or other licensed professional
- Special education for learning disabilities
- Speech therapy
- Stop-smoking programs including nicotine gum or patches
- Surgery, excluding cosmetic surgery
- Vasectomy
- Vision correction surgery
- Weight loss program, if it is a treatment for a specific disease diagnosed by a physician
- Women's care including abortion, birth control pills, pregnancy test kit
- Wheelchair
- Wig

*These are common services and expenses that **are not qualified medical expenses**:*

- *Costs or expenses reimbursed from another source*
- *Cosmetic surgery*
- *Diaper service*
- *Electrolysis or hair removal*
- *Heath club dues*
- *Household help*
- *Nutritional supplements for general good health*
- *Personal use items, such as toothpaste, toothbrush*

How can I access my HSA funds?

Your HSA comes with a Health Savings Debit MasterCard. It is an easy way for you to pay for any qualified out-of-pocket expenses. You may also order checks, but there is an additional charge.

There is also the option to make a payment directly from the Optum Bank website – www.optumbank.com. Just login and click on the "Make a Payment" link.

What are my HSA account options?

UnitedHealthcare's banking partner for Health Savings Accounts – Optum Bank – delivers a simpler and more personal experience through an innovative approach that allows you to customize your HSA to closely match your health care spending, savings patterns and overall financial philosophy.

Optum Bank offers the following account options to serve your UnitedHealthcare HSA plan:

- **Option #1 - OptumHealth eAccess HSA** — Low-cost HSA designed for active health care spenders who do not carry a large balance and prefer a lower monthly maintenance fee. No interest is paid on account balances.

  (The eAccess HSA will be the default option for all participants.)

- **Option #2 - OptumHealth eSaver HSA** — A good choice for a broad range of needs — easy access to pay current expenses, competitive interest rates, moderate fees and the option to invest balances in no-load mutual funds with no additional fee.

- **Option #3 - OptumHealth eInvestor HSA** — Designed for employees with less need to spend now, and who plan to contribute to and grow their HSA balances. You may invest any funds above $500 in the eInvestor versus $2,000 in the eSaver. Ability to invest more money in mutual funds by paying an additional investment fee.

Please Note: If you would like to change your HSA account type, call the number on the back of your HSA debit card [800.791.9361].

HSAs offer low monthly fees, in addition to competitive interest rates to help your account grow. A broad range of mutual funds that cover the spectrum of risk and rewards are also available.

Remember: Unused funds are yours just like a personal savings or checking account. Unlike a flexible spending account, there are no restrictions on how much you can have in your balance. There is no minimum amount that is required to be spent on a yearly basis.

The table below exhibits the main details of each of the HSA account options:

Your HSA Account Options[3,4]			
	Option #1 Health eAccess HSA	**Option #2 Health eSaver has**	**Option #3 Health eInvestor HSA**
HSA Account Options			
Monthly Maintenance Fee	Waived	$2.00 – waived if average balance is $5,000 or more	$2.00 – waived if average balance is $5,000 or more
Interest Rate	No interest earned on this account	Tiered interest rate based on account balance	Tiered interest rate based on account balance
Investment Options			
Investment Threshold/Minimum Balance Requirement[1]	$2,000	$2,000	$500
Monthly Investment Fee[2]	$3.00	N/A	$2.50

1. The bank account balance must remain at or exceed the Investment Threshold each time a new investment is made.
2. Investment Fee (where applicable) is only assessed after the establishment of an investment.
3. HSA account options are in effect for 2022 and may be subject to change for subsequent years.
4. For assistance with changing your HSA account type, call Optum Customer Service at 800.791.9361.

Are there fees associated with the HSA?

Some of the typical fees that you may be subject to under the Optum Bank Account are detailed below:

Fee Description	Fee
ATM Withdrawal	$2.50 per withdrawal*
Outbound Transfer Fee	$20.00 per transfer

* Fee may be subject to change.

Remember: By using your Health Savings Account Debit MasterCard, you can avoid many of the fees associated with your HSA. When you use your Debit MasterCard at the point of service, your monthly statements and online account information will show you exactly where you spent your HSA funds.

What are my investment options?

Persons enrolled in one of the District's High Deductible Health Plan options with an HSA deposit account at Optum Bank, Member FDIC, have the opportunity to invest a portion of their tax-advantaged HSA dollars in well-established mutual funds covering a diverse set of asset classes.

The Optum Bank Investment Account gives you the ability to invest for the future in mutual funds, complementing the interest-earning HSA Deposit Account. Like the HSA Deposit Account, investments in mutual funds roll over from year to year, accumulate in a tax-deferred manner, and are portable. To open an investment account, you must accumulate a minimum threshold.

The Optum Bank Investment Account provides you access to a number of mutual fund options, each investing in different types of securities with distinctive risk and return characteristics. Collectively, this selection of mutual funds has been designed to satisfy varied investment objectives and investment time horizons. While the mutual funds available through this service are not FDIC insured and expose investors to the risk of loss of principal, they provide the opportunity to earn higher returns than might be available in the HSA eAccess Deposit Account.

The ability to invest in mutual funds provides account holders with more flexibility and choice as they seek to manage their HSA assets. Click here to view the current fund offering.

For questions about your investment fund options, contact UnitedHealthcare's Customer Service at 800-562-6223.

Want More Information? View Optum Bank's HSA Webinar

Click here to watch an informal webinar about Health Savings Accounts, and your investment options. The webinar is designed to help you:

- Understand the contribution limits
- Fund to your max
- Understand the tax savings
- Learn about qualified health expenses
- Pay with your HSA
- Designate a beneficiary
- Manage your account
- Explore your resources
- Grow your savings

Who is eligible for a flexible spending account ("FSA")?

Health Care FSA – You are eligible for the District's Health Care FSA only if you are a participant in the PPO or Level2 Plan. (Silver + HSA and Gold + HSA participants are not eligible for a health care FSA, *as they have an HSA.*)

Dependent (Child or Elder) Care FSA – All employees are eligible for a Dependent Care FSA.

What types of FSA are offered?

District U-46 offers two FSAs to employees: a Health Care Account and a Dependent Care Account. FSAs offer you an opportunity to set aside pre-tax money from your paycheck for health-related and dependent care-related expenses. You can elect to contribute to one or both accounts if you do not elect a HDHP medical option, even if you do not enroll in either the dental or medical plan options.

- **Health Care Account** – can be used for certain medical, dental and vision expenses, prescription drug copays, vision exam and eyeglasses, orthodontia, medical and dental deductibles, copays, and coinsurance, for you and your eligible dependents that are NOT paid for by your health care plans. You may contribute up to $2,750 to your flexible Health Care FSA. The plan allows you to rollover up to $550 of unused 2021 Health Care FSA balance to the next year. Be sure to consider the rollover when electing your 2022 Health Care FSA deduction amounts. *You cannot rollover FSA funds from 2021 into 2022 if you elect the Gold + HSA or Silver + HSA health plans for 2022. This is due to IRS regulations which prevent you from having an FSA while enrolled in a HDHP.*
- **Dependent Care Account** – can be used to reimburse daycare expenses for your children, or for an adult dependent, so you are able to work. ***Due to the COVID-19 pandemic, you may use your remaining 2021 funds through the end of 2022, but 2022 balances can only be used through March 15, 2023.*** $5,000 is the maximum amount that may be contributed per family – two parents may each contribute separately, but the combined maximum contribution for a family cannot exceed $5,000. This account cannot be used for health care expenses and can only be used for your dependents.

FSA Direct Deposit

To simplify distributions from the District's FSA, employees can elect to have funds automatically distributed from their FSA account to their checking account by electing the direct deposit option. For employees who want to elect this option, log on to www.myuhc.com and click on "Claims & Accounts."

FSA Automatic Payment Settings

Employees who elect a Health Care FSA may choose to enable UHC's automatic payment feature which automatically submits any medical, pharmacy or dental expenses to the employee's Health Care FSA for reimbursement. This timesaving feature eliminates the need for a separate claim form and submission to the FSA. You will need to enable this feature as of January 1st by logging into www.myuhc.com and clicking on "Claims & Accounts". Then select the Plan Balances tab, select "Healthcare Flexible Spending Account", and click on "Manage Automatic Payment Settings." Please note you will need to activate this feature if you would like reimbursement payments to be sent to you from your FSA without submitting a claim for reimbursement.

Other Important Information

When determining how much you would like to contribute to your FSA, you should keep in mind the following:

- Only PPO and Level2 medical plan participants may contribute to a Health Care FSA. If you are enrolled in the Gold or Silver HDHPs, you may NOT have a Health Care FSA.
- You may not make a mid-year change in the amount elected to contribute to an FSA.
- The plan allows you to rollover up to $550 of unused Health Care FSA contributions to the following year if you enroll in and contribute to an FSA for that following calendar year. In other words, you must be enrolled in the PPO medical plan in 2021 and 2022 (PPO or Level2) in order to have a Health Care FSA's funds roll over from 2021 to 2022. *If you enroll in the Gold or Silver HDHPs for 2022 and have FSA funds left from 2021, they will be forfeited, since you cannot have a Health Care FSA with a HDHP.*
- Over-the-counter medicines and drugs (other than insulin) are only reimbursable if accompanied by a prescription.

The District's Wellness Program [Silver, Gold, and PPO Plans]

According to several studies, over sixty percent of health care costs are a result of life-style decisions that a person makes, such as diet and exercise. The District's Wellness Program is designed to assist participants in taking an active role in improving their health by:

- Assisting participants with understanding their health care risks,
- Helping them understand their own key biometric numbers,
- Providing them with programs and coaching that will assist them in making better decisions, and
- Encouraging physical activity.

There is a wellness base program and bonus program. The base program incentive s **$120 per eligible person**. For the bonus program, eligible members will receive **$20 every month** if they meet their daily "step goal" at least 12 times per calendar month.

Eligibility

An employee and spousal dependents who participate in one of the District's base medical options [Silver, Gold, or PPO Plans] are eligible to participate in the District's Wellness Program. A person may not have coverage as both an employee and as a dependent. ***Participants in the Level2 Plan have separate wellness benefits***. See page 24 for more information on wellness benefits under the Level2 Plan.

United Healthcare's Rally

District U-46 uses UnitedHealthcare's wellness health and wellness portal, Rally. Rally assists participants with tracking their completion of the wellness activities. In addition, Rally offers participants custom challenges and programs to engage participants to take an active role to improve their health.

What is Rally?

Rally is a user-friendly digital experience on myuhc.com that will engage you in a new way by using technology, gaming, and social media to support you on your health journey.

With the online Rally Health Survey, personalized missions, rewards, and connections to wearables like Fitbit®, Jawbone®, and more, it is easier for you to get motivated to be healthier. When you sign up for Rally, the first thing you'll learn is your Rally Health Age, which tells you how your body is feeling right now. Then you can start exploring all the great digital tools that may help you make healthier choices based on your life, schedule, and needs.

How do I track my progress in the base program?

The Rally portal is where your progress is tracked for qualifying for the Wellness Incentive. For the 2022 plan year, the wellness tracking period starts January 1, 2022 and ends on December 31, 2022. Progress is tracked as a percentage, and there are several alternatives to reach 100% completion status.

Although some activities are available for everyone, other activities will be customized based on your age and gender. For example, completion of the health survey is worth 30% and the annual physical is worth 30% of your required points. However, only women over the age of 40 will see completion of a mammogram as an option for earning points (30%).

Below is summary of the activities and their corresponding value:

Base Wellness Program		
Awareness	• Health Survey (Required)	**30%**
	• Biometric Screening	**10%**
	• Any of the following:	**20%**
	◦ BMI ≤ 27.5 or 2 pt. improvement	
	◦ A1c ≤ 6.3	
	◦ Total Cholesterol ≤ 210	
Activities	• Any one of the following:	**30%**
	◦ Annual Physical	
	◦ Prenatal visit	
	◦ Mammogram	
	◦ Cervical	
	◦ Colorectal	
	• Complete 3 Missions	**10%**
	• Complete a City Walk	**10%**
	• Use Healthcare Cost Estimator	**20%**
Programs	• Complete Real Appeal	**30%**
	• Complete Quit for Life	**30%**
	• Complete 30 workouts in Kaia	**30%**
Incentive	• Achieve 100%	
	• $120 payroll contribution payable in the quarter after completion	

The incentive for the base program is $120 per eligible person. The District will receive quarterly reports from UnitedHealthcare which will indicate employees and/or their spouses who have reached 100% completion for that quarter. Employees will be paid the incentive as taxable earnings on their regular paycheck approximately 2 months after the end of every quarter. You must be actively employed at the time the incentive is paid. No incentives will be paid to terminated or retired employees.

Health Survey (30%). In order for Rally to start tracking your progress, you will need to complete the online health survey in Rally. By completing the online health survey, Rally provides engagement through personalized recommendations, rewards, coaching, tools, community, and content that promotes healthy lifestyles.

Biometric Screening (10%). Due to the COVID-19 pandemic, the District is offering **at-home** biometric screenings instead of onsite screenings. To order an at-home screening kit:

- Visit www.myuhc.com, log in, and click "Employer Rewards" in the Rally section
- Click "Visit Quest" next to biometric screenings in the Available Activities section
- If you've never registered on the site, use the "Create Account" area
- Select "Order Materials" under At-Home Test in the Wellness Screening section
- Confirm the shipping address and hit "Next" to submit your order

In addition to an at-home biometric screening, participants may get a biometric screening through a participating Quest laboratory. Contact the Benefits Department at Benefits@u-46.org for more information.

Rally's Missions (10% for three completed missions). One of the best ways to make Rally work for you is to join Missions — simple activities you can fit into your daily routine to help you improve your diet, fitness, and mood.

Your responses to the Health Survey allow Rally to recommend Missions designed to create positive and lasting changes. Getting started is easy, and you can level up to more challenging options when you're ready.

A mission is a customized digital action plan designed to help you improve your life. Mission recommendations are made just for you under four categories: Move, Eat, Feel, and Care.

Each mission is designed to be simple, action-focused, and attainable. Missions meet you where you are and help you take small steps toward better health. Rally uses your responses to the Health Survey to determine which missions can be most helpful to you. For example, if you indicate in the survey that you don't exercise regularly, Rally might recommend easier missions in the MOVE category that could benefit your health and are within your reach. You can see your recommended missions by clicking the MISSIONS tab.

City Walk Challenge (10% for completed challenge). Rally lets you challenge yourself! Use a fitness tracking device to log your daily activity on one of its virtual courses and watch as your steps carry you around Chicagoland area. Compete as a team or against the entire Rally Health community. Either way, you will soon be pushing yourself to walk that extra block as you rack up Rally Coins and – even better – bragging rights.

Healthcare Cost Estimator (20%). Checking cost estimates before you choose where to get care can be an effective way to save money. In fact, studies have shown that people who look at costs first may pay up to 36% less for their care. There are a number of ways to find and compare costs using UnitedHealthcare's online tools. You can:

- Compare average costs for providers in the network used by the District's medical options, including doctors, hospitals, office visits, mental health services, labs, convenience care and more.
- See the average cost for specific treatments in your area.
- Look up quality ratings and reviews by provider, hospital, or facility.

To get your personalized cost estimates, sign in on www.myuhc.com to get the most accurate cost estimates for the plan you have:

- See how much you can expect your specific plan option will pay.
- Look up network providers for your plan to see cost and quality ratings.

Real Appeal – Weight Loss (30% for completing 9 sessions). The District offers United Healthcare's Real Appeal online weight loss program to you and your spouse at no cost as part of your health plan benefits. Real Appeal assists you to stay on track and lose weight with:

- A transformational coach who leads online group sessions,
- Digital tools to track your food, activity, and weight loss progress, and
- A success kit that includes scales, recipes, and workout DVDs.

You should talk to your doctor before starting any weight loss program.

Quit for Life – Smoking Cessation (30%). UnitedHealthcare's Quit for Life program assists members to quit smoking or using tobacco. Quit for Life provides:

- Tools and support to help members quit cigarettes, e-cigarettes, vaping, and tobacco,
- A personal, one-on-one Quit Coach to help you create a customized quit plan,
- The Quit for Life mobile app which offers 24/7 urge management support,
- Text2Quit text messages for daily tips and encouragement, and
- Quit medications, such as nicotine gum or patches, for no charge, based on eligibility.

Kaia – Complete 30 Workouts (30%). Kaia is the smart app that helps you fight pain, like back, shoulder, and neck pain, in as little as 15 minutes per day – weather you're already at the office, or you're about to go to bed. Kaia creates your own personalized program on your mobile phone, using scientific gold-standard techniques that are proven to reduce pain without medication or therapy.

What is the bonus wellness program?

Walking may be one of the easiest ways to maintain an active and healthy lifestyle. With Rally's STRIDE program, walking may even help you earn a bonus incentive. A member can select his/her target activity level (minimum of 5,000 steps per day) as a goal. A fitness-tracking device is used to monitor and sync steps.

Members will receive $20 every month if they meet their daily goal at least 12 times per calendar month. This reward is distributed online through gift cards. The amount can be accumulated for up to 12 months before being disbursed. The date of disbursement is a taxable event.

Members also earn Rally coins for each day the daily goal is achieved (even if they do not meet the monthly goal of 12 days). These coins can be used to win great rewards.

What are Rally Coins?

Nearly everything you do on Rally will earn you Rally Coins. You can redeem these for chances to win great rewards such as fitness trackers, gift cards, and more.

Earning Coins. The number of coins you can earn depends on the activities you complete. Below are some of the ways you can earn Rally Coins:

- Completing the Health Survey
- Placing first in a challenge
- Placing second in a challenge
- Placing third in a challenge
- Successfully completing a mission
- Successfully reaching a weekly mission
- Successfully reaching a daily mission
- Logging in on consecutive days
- Logging in once

Coin Balance. Your coin balance is always displayed below your username in the top right corner. It can also be found under the Rewards tab, where you will see a snapshot view of your overall balance and coin activity.

Redeeming Coins. Rally coins are good for entries into sweepstakes for a chance to win valuable rewards. Log in to Rally and check the Rewards section to see all available Rewards. From there, you can click each sweepstakes to see specific details – product details, the number of coins needed to enter, the number of days left to enter, etc. To enter a sweepstakes, simply click the Enter button. Your entry will be competing against the total Rally population.

Is there a mobile app?

There is now a mobile app for Rally that will allow you to take all the Rally features you love on the go. You can check into Missions, track your steps, see your progress in Challenges, use your Rally Coins, and more – all from the palm of your hand.

The Rally app uses the latest mobile technology, letting members track their steps with their phones, analyze their 30-day physical activity, and enjoy super-quick log-ins. They can earn 2X Rally Coins by joining the Mobile Mission of the Month.

Level2 Plan Wellness Program

The Level2 Plan includes its own wellness elements for members with type 2 diabetes, including wellness incentives, wearable technology, personalized coaching, and clinical care.

Wellness Incentives

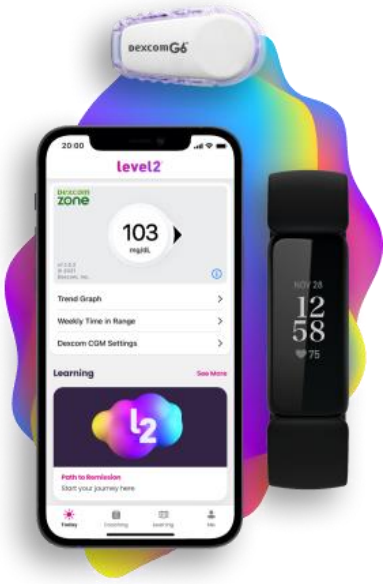
Members who enroll in the Level2 Plan will receive the following enhanced benefits specifically for their type 2 diabetes care for ***no cost*** if the diabetic family member wears his or her Continuous Glucose Monitor for at least 20 days each quarter:

- Continuous Glucose Monitor
- Diabetes drugs
- Level2 virtual care team visits
- Primary care visits
- Diabetic supplies
- Diabetes lab tests

These services would cost, on average, ***up to $2,000 to $3,000 annually*** for type 2 diabetics under the District's other plan offerings.

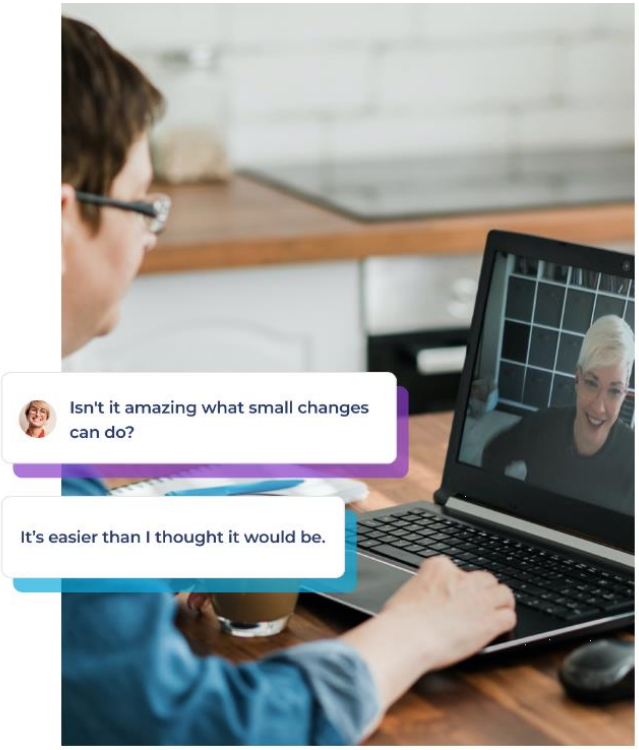
Wearable Technology

Know the impact in real-time. A Continuous Glucose Monitor and Fitbit are free with your enrollment in Level2. By tracking your glucose levels hundreds of times a day, you see in real time how food, sleep, and movement affect your body, without fingersticks, guesswork, or frequent doctor visits. Just tap the Level2 app to learn what works.



Personalized Coaching

Your ally in change. Your Level2 coach is there for one reason: to help you set realistic goals and succeed. They track your daily trends to provide clear direction based on your data and preferences. Connect anytime for answers and encouragement as much or as little as you need.



Clinical Care

Our whole team behind you. Available to you are a team of doctors, nurses, nurse practitioners, dietitians, and more as close as our virtual clinic. They monitor your progress and evaluate your need for medications and other forms of care. Instead of doubts or lectures, you get caring people who genuinely believe in your ability to change.

Mid-Year 2022 Retirees Ineligible for Level2

Retirees are in-eligible to participate in the Level2 plan. As a result, mid-year 2022 retirees, who elected the Level2 plan, may move to the Silver, Gold, and PPO Plans.

Managing Your Health Costs

How can I manage my health care costs?

Below are some ways you can better manage your health care costs:

1. Use an "In-Network" provider

Using in-network physicians and facilities, who have deep discounts, is the most effective way to use your health care benefits. The plans pay a higher level of benefit when you use in-network providers.

2. Use a Premium Designated Provider

The UnitedHealthcare Premium Designated Program recognizes physicians and facilities for meeting quality and cost-efficiency guidelines. The cost efficiency evaluation uses population cost and/or episode cost measurement, depending on the specialty being assessed.

Premium Designated Physicians have been recognized for providing *both quality and cost-efficient care* to their patients.

- **Quality Designated Physicians** must meet national industry standards of care.
- **Cost Efficiency Designated** Physicians must meet local benchmarks for efficiency in delivering health care.

To find a physician, log onto www.myuhc.com and click on "Find a Physician or Facility" and locate the premium designated physicians.

3. Use the Mail Order or 90-Retail Pharmacy Benefit

If you are on maintenance medications, you should get a 90-day prescription which can be filled through mail order or at a network pharmacy. The prescription portion of your medical plan provides you a discount when you do a 90-day prescription. For example, if a person takes two Tier 1 and two Tier 2 maintenance drugs every month for a year, that person would save $200 by getting a 90-day prescription over getting a 30-day prescription.

4. Use the Drug Pricing Tool

The Drug Pricing Tool lets you search for medications before filling prescriptions at the pharmacy. Pricing is based on your specific benefit plan and will include costs at the OptumRx® Mail Service Pharmacy and local retail pharmacy. The tool will display any lower-cost options to help you to make informed decisions about your medication options.

You can access the Drug Pricing Tool by logging on to www.myuhc.com and selecting Pharmacies and Prescriptions tab. Click on "Go to OptumRx". Then select the Member Tools tab and then "Drug Pricing".

5. Use the Health Care Cost Estimator

Checking cost estimates before you choose where to get care can be an effective way to save money. In fact, studies have shown that people who look at costs first may pay up to 36% less for their care. There are a number of ways to find and compare costs using UnitedHealthcare's online tools. You can:

- Compare average costs for providers in the network used by the District's three medical options, including doctors, hospitals, office visits, mental health services, labs, convenience care and more.
- See the average cost for specific treatments in your area.
- Look up quality ratings and reviews by provider, hospital, or facility.

To get your personalized cost estimates, sign in on www.myuhc.com to get the most accurate cost estimates for the plan you have.

6. Use UnitedHealthcare Allies Discount Program

The UnitedHealthcare discount program helps you and/or your family save 10 to 50 percent on many health and wellness purchases not included in your standard health benefit plan. Examples of some of the discounts that are offered include:

- Cosmetic dental care
- Alternative care such as massage therapy and natural medicine
- Health supplies
- Fitness club membership
- Teeth whitening

To learn more about the discounts available to you, log in to www.myuhc.com and click on "Extra Programs & Discounts".

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Voluntary Vision Program

Participation in the vision program is voluntary. If you enrolled in the vision plan in 2021, and want to keep the same selection, you must click the "No Changes" button next to the vision section during Open Enrollment to retain your coverage for 2022. If you were not enrolled in 2021, you will not be enrolled for 2022 unless you make a positive election in Munis Self Service.

Vision Plan Design Summary

Below is brief summary of the vision program insured by EyeMed:

Vision Care Services	In-Network	Out-of-Network
Eye Exam	$0 copay	$60
Fundus Photography Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-up*	Paid in full fit and two follow up visits	$40
Premium Contact Lens Fit and Follow-up**	10% off Retail, then $55 allowance	$40
Frames (any available frame at provider location)	$0 copay, $150 allowance, 20% off balance over $150	$58
Standard Plastic Lens		
Single Vision	$10 copay	$25
Bifocal	$10 copay	$40
Trifocal	$10 copay	$55
Standard Progressive Lens	$75 copay	$40
Premium Progressive Lens	Varies (see price list)	$40
Lens Options		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Std. Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Photocromatic/Transition Plastic	$75	N/A
Other Add-ons and Services	20% off retail price	N/A
Contact Lens (includes materials only)		
Conventional	$130 allowance, 15% off balance over $130	$92
Disposable	$130 allowance, plus balance over $130	$92
Medically Necessary	$0 copay, paid-in-full	$200
Laser Vision Correction	15% off retail or 5% off promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lens or Contacts	Once every 12 months	
Frames	Once every 24 months	

NOTES TO CHART
* Standard Contact Lens Fitting – spherical clear contact lenses in conventional wear and planned replacements (Examples: disposable, frequent replacement, etc.)
** Premium Contact Lens Fitting – all lens designs, materials, and specialty fittings other than Standard Contact Lenses (Examples: toric, multifocal, etc.)

The District uses EyeMed's Insight Network. This network includes Pearle Vision, LensCrafters, Sears Optical, Target Optical, JCPenney Optical, and many other providers.

Vision Rates for Active Employees for 2022

Employees pay for the vision benefit through pre-tax deductions every payroll. The District will contribute 50% towards the overall cost of coverage with participants contributing the remaining 50%. However, a dependent veteran child will pay 100% of the premium. Employee rates are listed below:

Tier	Total Premium	Employee Portion	EE Contribution Per Pay Period	
			26 pay periods	19 pay periods
Employee	$92.00	$46.00	$1.76	$2.41
EE + Spouse	$174.00	$87.00	$3.34	$4.57
EE + Children	$182.00	$91.00	$3.52	$4.81
Family	$268.00	$134.00	$5.17	$7.07
Dep Vet Child	$92.00	$92.00	$3.52	$4.81

PLEASE NOTE: You have the option to enroll in one of four medical options and choose not to enroll in the vision option. Or, you may choose not to enroll in of the four medical options while choosing to enroll in the vision program. In addition, you may select different coverage tiers for each benefit option, such as, family coverage for medical and employee only for vision.

The Vision Program is insured by EyeMed.

Voluntary Dental Program

If you meet the eligibility requirements, you may enroll yourself and your dependents in the voluntary dental program. Your dental and medical options are independent. You have the option to enroll in one of the four medical options and choose not to enroll in the dental program. Or, you can choose to enroll in both the dental program and one of the four medical options. In addition, you may select different coverage tiers for each benefit option, such as, family coverage for medical and employee only for dental. The dental program is a PPO administered by UnitedHealthcare.

Because the dental program is voluntary, if you were enrolled in the dental program in 2021, you must click the "No Changes" button next to the dental section during Open Enrollment to retain your coverage for 2022. If you were not enrolled in 2021, you will be automatically enrolled in single dental coverage for 2022 unless you waive coverage or make a positive election for a different coverage tier in Munis Self Service.

Dental Plan Design Summary

Benefit Type	Coverage Level
Annual Benefit Limitation	$2,500 per covered person
Preventive Care	
Annual Deductible	No deductible
Coverage Level	100%*
Restorative, Major and Orthodontic Care	
Annual Deductible	$25 per person; $75 per family
Restorative Coverage	80%*
Major	50%*
Orthodontic	50%*
Lifetime Orthodontic Maximum	$2,000 per person

* Patients may see either a network dentist or an out-of-network dentist. However, the amount paid by the plan to an out-of-network dentist will be based upon 90% of the Reasonable and Customary charge for that service. The patient may be responsible to pay the balance if the amount charged is greater than the 90% of the Reasonable and Customary charge for that service. If a network dentist is used, the patient is not responsible for charges exceeding the network-allowed fees.

Providers in the School District U-46 Dental Program can be viewed here.. Select "Provider Search" and then enter "National Options PPO 30" as the network.

Prenatal Dental Care Program

Understanding that there are severe negative consequences to poor dental hygiene, UnitedHealthcare has created the Prenatal Dental Care Program, a special benefit for expectant mothers throughout their pregnancy and the first three months following delivery. This program provides for specific dental services, including:

- Dental cleanings,
- Deep scaling (non-surgical gum treatment), and
- Periodontal (gum) maintenance.

These services are covered at 100% and do not apply toward your annual maximum and do not apply toward your deductible.

Dental Rates for Active Employees for 2022

For employee only coverage, the District will cover the entire cost of the dental benefit for full-time employees. The remaining coverage tiers involve an element of cost sharing on behalf of the participant.

Overall, the dental rates decreased by approximately 0.8% from last year. Employee rates are listed below:

Tier	Total Premium	Employee Portion	EE Contribution Per Pay Period	
			26 pay periods	19 pay periods
Employee	$657	$0	$0.00	$0.00
EE + Spouse	$1,348	$690	$26.55	$36.33
EE + Children	$1,131	$473	$18.21	$24.92
Family	$1,874	$1,216	$46.78	$64.02
Dep Vet Child	$657	$657	$25.29	$34.60

Visit myuhcdental.com

To locate a dentist, review your coverage, check your dental claims, and learn more about oral health and dental treatments, visit myuhcdental.com. Additionally, you can compare costs using the dental cost estimator.

Supplemental Life Insurance

Supplemental life insurance is offered to eligible employees through The Standard Insurance Company (The Standard). Employees will pay for this coverage through after-tax payroll deductions.

Your Options Without Evidence of Insurability

Existing coverage will automatically continue, but you must click the "No Changes" button next to your election in Munis Self-Service. Because rates are based on your age as of January 1, 2022, your actual cost may increase if you change age bands.

You may **increase your coverage** and your spouse's coverage by $10,000 up to $250,000 for yourself or $50,000 for your spouse without evidence of insurability. If you elect to increase coverage for either you or your spouse, you will need to *enter the new **total** amount* of coverage in Munis.

You may elect life insurance for **dependent children** up to age 26 if you elect at least $10,000 of supplemental coverage for yourself. The premium of $2.00 per month providers $10,000 for each eligible child, regardless of the number of children you have. If your spouse works for the District, children may only be covered by one parent.

Your Options with Evidence of Insurability

Employee Coverage. You may purchase life insurance coverage in increments of $10,000 up to $400,000. Evidence of Insurability is required if the total is greater than $250,000.

Spousal Coverage. Spousal coverage may be purchased in $10,000 increments up to $250,000. The coverage for a spouse cannot exceed the amount of your coverage. Evidence of Insurability is required if you increase your existing coverage by more than $10,000 per year or if the total is greater than $50,000.

Evidence of Insurability For 2022

During this year's special enrollment period, you may elect up to $250,000, but not to exceed 2 times your annual earnings in supplemental life insurance, or increase your supplemental life insurance up to $250,000, but not to exceed 2 times your annual earnings, without evidence of insurability. After this special enrollment period, evidence of insurability may be required.

The evidence of insurability form may be completed electronically through The Standard here.

If you have a life event which qualifies you to make a change, you may be required to provide evidence of insurability for certain levels of coverage. Examples of life events which would allow you to make a change include marriage, the birth of a child, etc. The enrollment must occur within 31 days of the life event.

Supplemental Life Insurance Rates

The rates for supplemental life insurance are as follows:

Age of Employee/Spouse as of January 1, 2022	Rate per Month Per $10,000
<30	$0.58
30-34	$0.58
35-39	$0.69
40-44	$0.78
45-49	$1.04
50-54	$1.27
55-59	$1.84
60-64	$3.22
65-69	$4.83
70-74	$8.97
75-79	$14.84
80+	$40.37
Child(ren)	$2.00

UnitedHealthcare

- Phone: Call Customer Care at the number found on the back of your ID card: 877-369-1196
  If you don't have your ID card, call 866-633-2446.
- Web: www.Myuhc.com

UnitedHealthcare's OPTUMRx Mail Service Pharmacy

- Phone: 800-562-6223
- Web: Log in to myuhc.com and click on "Pharmacies and Prescriptions." From there, click on "OPTUMRx."

HSA - Optum Financial

- Phone: 866-234-8913
- Web: www.optumbank.com

FSA

- Phone: 800-243-5543

Rally Technical Support

- Phone: 877-818-5826

Vision (EyeMed)

- Phone: 866-9EYEMED
- Web: www.eyemedvisioncare.com

Dental (UnitedHealthcare)

- Phone: 877-816-3596
- Web: www.myuhcdental.com

Life Insurance, Voluntary Critical Illness Insurance, Voluntary Hospital Indemnity Insurance (Standard Insurance Company)

- Phone: 888-937-4783
- Web: https://www.standard.com/

School District U-46 Benefits Team

- Phone: 847-888-5000, extensions 5026, 5563 or 4264
- Email: Benefits@U-46.org

The 2022 Open Enrollment Guide is an internal publication of School District U-46, Kane, DuPage, and Cook Counties, Illinois, which is published by the Human Resources Department. It is intended solely for employees of the District. Receipt of this publication is not an indication that an employee is eligible for benefits under the District's benefit programs. The Guide is a brief summary of benefits offered by the District for its employees effective January 1, 2022. The applicable plan documents shall govern if there is a discrepancy between this document and the actual provisions of the programs.

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