Flexible Benefit Plans for Calendar Year 2014

The District 211 Flexible Benefit Plan allows employees to make contributions toward the cost of health and/or dental insurance on a tax-exempt basis. In addition, employees may make contributions on a tax-exempt basis to medical and/or dependent care reimbursement accounts for qualified medical and/or dependent care expenses not covered by insurance.

2014 Flexible Benefit Plan Enrollment

In accordance with Section 125 of the Internal Revenue Code (I.R.S.), employees will have the opportunity to enroll (or make new elections if already enrolled) at the beginning of each plan year. The current plan will end on December 31, 2013. The open enrollment period for employees who wish to participate in the 2014 Flexible Benefit Plan will be held from November 1 through November 15, 2013. I.R.S. regulations mandate an annual enrollment for all flexible spending plan participants. **Employees who are currently participating in the 2013 flexible spending plan and wish to continue participation for 2014 MUST complete the 2014 flexible spending enrollment through the District 211 Intranet.**

Employees May Enroll in the Following Options

- **Pre-Tax Premium Option 1**
  All 2014 health and dental premiums may be paid on a tax-exempt basis.
- **Medical Reimbursement Account Option 2**
  If you are currently enrolled in this option and would like to continue participation in 2014, *you must complete a new enrollment for 2014.*
- **Dependent Care Reimbursement Account Option 3**
  If you are currently enrolled in this option and would like to continue participation in 2014, *you must complete a new enrollment for 2014.*

The I.R.S. Flexible Spending Plan 14½ Month Rule

An employee who is participating in the flexible spending plan has a reimbursement period for both the medical and dependent day care spending accounts for a period of fourteen and one-half (14-1/2) months. Participants may be reimbursed from the same flexible spending account for expenses incurred during the plan year and for expenses incurred 2½ months after the plan year ends. Using 2013 as an example, a District 211 employee who has a flexible spending account may be reimbursed for services provided January 1, 2013, through March 15, 2014, from their 2013 flexible spending account. It is important to note that a participant is required to use 2013 flexible spending dollars before reimbursement from a 2014 account can take place.

Flex Plan Reimbursement Deadline:

All reimbursements must be submitted to Discovery Benefits by April 15 following the plan year.

Health/Dental/Flexible Spending Intranet Enrollment Procedures

STEP 1: Open a web browser and go to the new District 211 website at: *http://adc.d211.org*

STEP 2: On the main menu, roll your mouse over INFO and go to the last item on the dropdown list, which is INTRANET, and click on it.

STEP 3: Enter your network username and password. If you do not have district email, enter *User Name:* **District211Employee** and *Password*: **employeeaccess** (case sensitive). Click on **Sign In**.

211 Please identify yourself:
Use your network user name and password.
User name:
Password:
Sign In

STEP 4: Enter your 6-digit employee ID number and click on Submit.

Please Enter Employee Authorization Code:
Submit

STEP 5: Click on the "Health Insurance Plan Info" link.

Job Requests
ProQuest Professional Education Collection
Activity Sponsors Handbook ~ Coach's Handbook
Employee Benefits
Health Insurance Plan Info
Wellness Physical Exam Program
403(b) Tax Sheltered Annuity Plan
Life Insurance
· Life Insurance Booklet – Teachers Union
· Life Insurance Booklet – Non-Certified 37.5 Hours

STEP 6: Follow the on-line enrollment instructions.

Township High School District 211

Health, Dental, and Flexible Spending Plan Enrollment for 2014

Open Enrollment Timeline

Your 2014 Health, Dental, and Flexible Spending Plan open enrollment will take place **November 1 through November 15, 2013.** All employees are required to complete an annual insurance enrollment via the District 211 Intranet. (Even if you plan to elect the same insurance coverage as 2013 or decline coverage, you must complete the on-line enrollment.)

Please refer to the back page for information regarding the Intranet enrollment procedures.

Where to send your completed enrollment information

Once you have completed your insurance and flexible spending plan enrollment on the District 211 Intranet, please print your enrollment forms, sign, and send via the inter-district mail to the Business Office, G.A. McElroy Administration Center, attention of Mary K. Oakes, ***no later than Friday, November 15, 2013.***

Flexible Spending for 2014

- **Medical Reimbursement**
  The Medical Reimbursement limit for 2014 remains at $2,500 per employee.
- **Dependent Care Reimbursement**
  The Dependent Care Reimbursement limit for 2014 remains at $5,000 per family.

Annual Notifications

The following annual notifications are available on the District 211 Intranet:

CHIP - Children's Health Insurance Program
Medicare Part D - Creditable Coverage
Notice of Privacy
Notice Regarding Health Insurance Coverage for Dependents
WHCRA - Women's Health & Cancer Rights Act of 1998

See *"Answers to the most frequently asked questions"* for "Grandfathered Plans" notification.

Open Enrollment Meetings

Open enrollment meetings have been scheduled and are intended to provide a general overview of the insurance plans and enrollment procedures, as well as afford employees and their families an opportunity to have specific questions addressed. Representatives from Blue Cross/Blue Shield and the District's insurance consulting firm of CBC will be available during these meetings to assist with questions. Employees and spouses are welcome to attend any of the following meetings:

DATE	BUILDING	LOCATION	TIME
Monday, October 21	Hoffman Estates High School	Room 235	3:00 p.m.
Tuesday, October 22	Fremd High School	Room 200	3:00 p.m.
Thursday, October 24	District 211 Academy-North	Cafeteria	8:00 a.m.
Thursday, October 24	Administration Center	Board Room	10:30 a.m.
Thursday, October 24	Schaumburg High School	Room 200	3:00 p.m.
Tuesday, October 29	Palatine High School	Room 388/390	4:00 p.m.
Tuesday, October 29	Administration Center	Board Room	7:00 p.m.
Wednesday, October 30	Conant High School	Room 111A	4:00 p.m.
Thursday, October 31	District 211 Academy-South	Cafeteria	8:00 a.m.

Health / Dental / Vision Reference Information

Danielle Powers, CBC 847-390-5669
Maria Martinson, CBC 847-390-5672
PPO Customer Service 800-458-6024
PPO/HMO Provider Finder 800-810-2583
Mental Health/Chemical Dependency 800-851-7498
Medical Service Advisory 800-826-8551
HMO Customer Service 800-892-2803
Prescription Drugs 800-423-1973
Prime Therapeutics (mail order prescriptions) 800-423-1973
Dental 800-367-6401
VSP Vision Insurance (PPO2 and PPO3) 800-877-7195
Davis Vision (Discount Program) 877-393-8844
Discovery Benefits - Flex Plan 866-451-3399
Business Office .... ext. 6649

WEBSITE INFORMATION

Blue Cross/Blue Shield .... www.bcbsil.com
VSP Vision .... www.vsp.com
Discovery Benefits .... www.discoverybenefits.com
District 211 Intranet www.d211.org
Prime Therapeutics .... www.myprime.com

Comparison

Medical Plan Design Options for period January 1 - December 31, 2014

PPO - HSA		HMO
In Network	Out-of-Network	
Unlimited		Unlimited
$1,500		None
$3,000**		None
$3,000	$6,000	$1,500
$9,000	$18,000	$3,000
90% after ded.	70% after ded.	100% no copayment
90% after ded.	70% after ded.	100% no copayment
90% after ded.	70% after ded.	100% no copayment
$75 copay* then 100% after deductible		100% after $75 copayment
60% after ded.	50% after ded.	100% no copay/20 visits per CY
60% after ded.	50% after ded.	100% after $20 copay/20 visits per CY
90%* after ded.	70%* after ded.	100% no copay/60 visits per CY
90% after ded.	70% after ded.	100% after $20 copayment
90% after ded.	70% after ded.	100% after $20 copayment
90% after ded.	70% after ded.	100% after $20 copayment
90% after ded.	70% after ded.	100% after $20 copayment
90% after deductible		N/A
80% after ded.	N/A	$10 / $20 / $35
N/A	N/A	90 Day Supply/2 copays

examinations, or procedures.

***Covered family members are eligible for benefits to be paid by the plan after entire family deductible has been satisfied.*

Dental Benefit Summary

Deductible	$50 per benefit period
Preventive Services Benefit Payment Level	80% of the U&C Fee*+
Primary Services Benefit Payment Level	80% of the U&C Fee*
Major Services Benefit Payment Level	50% of the U&C Fee*
Benefit Period Maximum	$2,000
Orthodontic Services Benefit Payment Level	50% of the U&C Fee II✰✰
Dependent Eligibility	Children to age 26

* Usual and customary fee
✰✰ Dependent children under age 19
+ Deductible does not apply

Vision Plan Benefits Summary

100% Employer Paid premium with PPO2 and PPO3 only
Vision Plan is insured through VSP Insurance (not BC/BS)

	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	100% after $10 copay Once every 12 mos.	Reimbursed up to $25
Lenses	100% after $25 copay Once every 24 months	Reimbursed up to: $30 (single vision) $35 (bifocal lenses) $45 (trifocal lenses) $60 (Lenticular lenses)
Frames	100% after $25 copay Once every 24 months	Reimbursed up to $45
Contact Lenses (Elective)	Up to $120 allowance	Reimbursed up to $120
Contact Lenses (Necessary)	100%	Reimbursed up to $120
Lasik Eye Surgery	Discount Program Only	Discount Program Only

NOTE: The information in this brochure is for comparison purposes only. For details and further information, please see the plan document of coverage, which outlines all the plan provisions and legally governs the operations of the plans.

This and other benefit information is available on the District 211 Intranet under Health Benefits.

Benefits Summary

BENEFITS	PPO - 1 In Network	PPO - 1 Out-of-Network	PPO - 2 In Network	PPO - 2 Out-of-Network	PPO - 3 In Network	PPO - 3 Out-of-Network
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Single Deductible	$300		$300		$500	
Family Deductible	$900		$900		$1,500	
Out-of-pocket limit						
Individual	$900	$3,500	$900	$3,500	$1,500	$4,500
Family	$2,700	$12,000	$2,700	$12,000	$4,500	$18,000
Inpatient Hospital	80%	60%	80%	60%	80%	60%
Outpatient Surgery	100%+	80%	90%+	60%	80%+	60%
Outpatient Hospital	100%+	80%	90%+	60%	80%+	60%
Outpatient Emergency	100%+	100%+	$100 copay*+ then 100%		$100 copay*+ then 90%	
Inpatient Mental Health	80%	60%	80%	60%	80%	60%
Outpatient Mental Health	60%	50%	60%	50%	60%	50%
Therapy - Speech, Physical & Occ.	90%	80%	90%	80%	80%*	60%*
Medical Surg. Care	90%	80%	90%	80%	80%	60%
Outpatient Physician Surgery	100%+	80%+	100%+	80%+	80%+	60%+
Chiropractic Services	90%	80%	90%	80%	80%*	60%*
Well Child Care (up to age 16)	90%+	80%+	80%+	60%+	80%+	60%+
Private Duty Nursing	90%		80%		80%	
Prescription Drugs						
Retail	$5 copay* generic $10 copay brand	75% after applicable copay*	$10 copay* generic $20 / $35	75% after copay* $10 / $20 / $35	$10 copay* generic $20 / $35	75% after copay* $10 / $20 / $35
Mail Order	$5 copay* 90 Day Supply/1 copay	N/A	$10/$20/$35 copay 90 Day Supply/1 copay	N/A	$10/$20/$35 copay 90 Day Supply/1 copay	N/A

IMPORTANT TO NOTE: PPO Plans do NOT provide coverage for routine physicals,

Employees may apply shared savings toward their premium contribution as shown, or a flexible spending account, health savings account, or receive shared savings in cash.
*+Deductible does not apply. *The co-insurance and/or copayments do not apply to any out-of-pocket expense limitation.*

Township High School District 211
Health & Dental Employee Rates - 2014

For 2014, the District's health insurance program will offer employees a choice of four Preferred Provider Organization (P.P.O.) variants including a Health Savings Account (H.S.A.) option, a Health Maintenance Organization (H.M.O.) option, and a cash-out option for employees not electing coverage. The plan options offer varied levels of benefit coverage, deductibles, coinsurance, premium rates, and shared savings (cash incentives) to employees. The following insurance rates/incentives are established for the period January 1, 2014 through December 31, 2014.

EMPLOYEE HEALTH COVERAGE COST FOR 2014

Single Coverage	PPO-1	PPO-2	PPO-3	HSA	HMO	CASH-OUT
Employee Premium Contribution	$3,356.83	$1,434.77	$977.95	$571.38	$311.46	N/A
Shared Savings	$0.00	($377.39)	($704.49)	($1,339.11)	($1,081.45)	$1,000.00
Employee cost (before taxes)	**$3,356.83**	**$1,057.38**	**$273.46**	**($767.73)**	**($769.99)**	**N/A**
Family Coverage						
Employee Premium Contribution	$11,329.76	$5,811.30	$4,402.06	$2,314.71	$1,681.95	N/A
Shared Savings	$0.00	($1,018.62)	($1,899.99)	($3,614.06)	($2,920.02)	$1,000.00
Employee cost (before taxes)	**$11,329.76**	**$4,792.68**	**$2,502.07**	**($1,299.35)**	**($1,238.07)**	**N/A**

Shared Savings Options
1. Apply toward employee premium contribution.
2. Deposit in a flexible spending account and/or health savings account (HSA participants).
3. Receive the shares savings in cash (taxable).

EMPLOYEE DENTAL COVERAGE COST FOR 2014

	Single	Family
7.5 - 8 HRS.	$0	$78.00
4 - 7 HRS.	$520.65	$1,434.34

Township High School District 211

Answers to the most frequently asked questions

What is a Deductible?
A deductible is the amount of money you or your dependents must pay toward your medical bills before the health plan makes any payments for health care services rendered. The individual deductible is the amount that must be satisfied per person on an annual basis. Once the cumulative total of deductible paid by all family members reaches the family deductible amount, no one else in the family is required to meet any more deductible charges.

What is a Co-payment?
A co-payment is a specific dollar amount the member must pay for the service or prescription and the deductible does not have to be satisfied first. Co-payments do not apply to deductibles.

What is Coinsurance?
Coinsurance is a provision in your health plan that describes the percentage of a medical bill that you must pay and that which the health plan must pay after the deductible is met.

What is Out-Of-Pocket Maximum?
When a plan member pays coinsurance, there is a limit to how much coinsurance they are responsible for. Like a "safety net," once the maximum out of pocket is met, then the health plan begins to cover eligible expenses at 100%.

What is an Explanation of Benefits (EOB)?
An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment from a provider.

What is a Pre-Existing Condition?
A pre-existing condition is a physical or mental condition that existed prior to being covered on a health benefit plan. The health plan will not pay for treatment related to a pre-existing condition for one year, UNLESS the member has had continuous coverage for 18 months prior to plan enrollment.

What is a Preferred Provider Organization (PPO)?
A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service. These providers have agreed to a discounted, contracted rate for services rendered. A PPO plan also features coverage for services rendered in the network, and a lower level of coverage for services rendered out of the network.

What is a Health Maintenance Organization (HMO)?
An HMO is a health plan that provides coverage only for services received by health care providers who contract with the plan. Emergencies are always covered regardless of where treated. Patients must choose a primary care physician (PCP) who then coordinates and directs all of a patient's care. Medical services received outside of the PCP's office will only be covered if directed by the PCP. Emphasis is placed on preventive care and medical management. Unlike a PPO, an HMO provides benefits within the HMO network of providers, but most services are typically covered at 100%.

What is a Health Savings Account (H.S.A.)?
Health Savings Accounts (H.S.A.s) are a newer option for health insurance plans, and have two parts. The first part is a PPO health insurance policy that only begins to cover medical and prescription services after the plan deductible has been met. The second part of the plan is the actual Health Savings Account. This account can be funded by the employer and/or the employee, and is a tax-free savings account utilized to pay for day to day medical and prescription drug services. Any unused funds in the account are owned by the employee, and "roll-over" from year to year. In addition, the dollars in an H.S.A. can be used to pay for COBRA premiums, and the money can accumulate with tax-free interest until retirement, when you can withdraw for any purpose and pay normal income taxes.

Can HSA Participants also contribute to a Medical Flexible Spending Account (FSA)?
Yes, on a limited basis. In a "Limited FSA," eligible expenses are generally limited to qualifying vision and dental expenses only.

What are in-network services?
If a plan member receives services from a provider that is "in-network," benefits will be paid at the highest level. An in-network provider has a contract with the health plan to accept a discounted rate as payment in full, resulting in less out of pocket expense to the member.

What are out of network services?
If a plan member receives services from a provider that is out of the network, benefits will be paid at a lower percentage than those in-network. In addition, there is no contract with the provider to accept a discounted fee, which can result in the provider charging a much higher fee than the health plan standard payment.

What is an eligible dependent?
An eligible dependent is an individual who must meet one of the following criteria: a legally married spouse of an eligible employee; a dependent child by birth, marriage, legal adoption, legal guardianship, or one who is in the custody of the employee under a court order and who is under the limiting age of the policy. Children who are not living with the employee, but for whom the employee is required by law to provide health care coverage, also will be covered, in addition to children who are dependent on the employee for support and maintenance because of a disability. Grandchildren and foster children are generally not eligible for coverage unless they have been legally adopted or placed for adoption. Dependent children are covered until age 26. A military dependent who is not married may be eligible for coverage until age 30. Domestic partners and civil unions may also be eligible for plan coverage. For further clarification on dependent eligibility, please contact the business office at x6649.

What is Blue Care Connection (BCC)?
Blue Care Connection (BCC) is Blue Cross Blue Shield of Illinois' suite of medical care management programs. The Medical Services Advisory (MSA) falls under BCC. The MSA reviews all cases (elective surgery and emergency room visits) that require pre-certification for medical necessity determination. PPO members must call the MSA within one business day of an elective admission or within two business days of an ER visit or maternity admission.

What is "Coordination of Benefits?"
Coordination of Benefits (COB) is a method of determining which insurance carrier has primary responsibility for payment of medical treatment. If you, the employee, also have coverage under another health plan, and are actively at work, your coverage with the District will be primary.

What is a "Generic" Prescription Drug?
When a drug's patent expires, other companies can make copies of the original drug. Generic drugs contain the same medicine as the original brand name and are equivalents of brand name drugs. They share the same chemical, or generic, name as their brand name counterparts and must meet strict FDA requirements to be manufactured. Generic drugs are equally as safe and effective as brand name drugs and treat the same medical conditions. Although lower in cost, generic drugs offer the same usefulness as brand name drugs.

What is a "Brand-Name" Prescription Drug?
A brand-name drug is a drug that has been given a brand name by its manufacturer. When a new drug is developed, the manufacturer applies for a patent, which gives them the exclusive right to produce and distribute that drug for a certain number of years before a generic equivalent can be made. This also gives the manufacturer the right to name its product. Manufacturers of drugs pick unique, usually memorable names to promote product recognition.

What is a Prescription Drug Formulary?
A formulary is a health plan's preferred drug list made up of brand-name and generic drugs that have been approved by the FDA as safe and effective. These also are drugs that have been on the market long enough to stand the "test of time." A health plan constantly reviews and updates the prescription drug formulary.

What is a "Non-Formulary" Prescription Drug?
A non-formulary drug is a covered (medically necessary) prescription drug that does not appear on the health plan's "preferred drug" listing. Non-formulary drugs are typically drugs that are new on the market, overly expensive, or do not have a proven efficacy for the condition it is supposed to treat. Non-formulary medications are covered by the health plan, but at a higher co-payment.

Where can I find more information about the PPO and HMO plans?
A Summary of Benefits and Coverage (SBC) for each of the PPO and HMO plans can be found on the District 211 Intranet.

"Grandfathered Plan" Notice
Township High School District 211 believes all plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Christopher J. Kontney, Director of Business Services, at 847-755-6648.