2021

Employee Benefits Overview

April 1, 2021 Attention New Employees: The PPO Insurance option is no longer available.

Current employees are able to join the PPO option during the Fall 2021 Open Enrollment.

For more information, please contact the Business Office at 708/741-5604.

~~November 1, 2020~~

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on page 20 for more details.

We've Got You Covered.

At Oak Lawn Community High School District #229 we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

Who Can You Cover?

WHO IS ELIGIBLE?

In general, full time employees working 30 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.*

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your children:
  - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

*You must provide documentation of dependent eligibility. For a spouse, provide a copy of your marriage or civil union certificate. For children, provide a copy of birth certificates, adoption or legal custody documents, etc. For a list of acceptable documents, contact the Business office.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of Oak Lawn Community HS Dist. 229 cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new hires begins on the 1st day of the month following employment.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify the Business office within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Medical

BlueCross BlueShield of Illinois

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

Medical coverage is provided through BlueCross BlueShield of Illinois (BCBSIL).

	BlueAdvantage HMO Plan	BlueEdge HSA Plan	
	Network Only; PCP required	In-Network	Out-Of-Network
Annual Deductible	None	$2,800 single $5,600 family	$5,200 single $10,400 family
Annual Out-of-Pocket Maximum (includes deductible)	$1,500 single $3,000 family	$2,800 single $5,600 family	$10,400 single $20,800 family
Physician Services			
Primary Provider	$20 copay	Plan pays 100% after deductible	Plan pays 80% after deductible
Specialist	$20 copay (referral required)	Plan pays 100% after deductible	Plan pays 80% after deductible
Virtual Visits	Not Available	Plan pays 100% after deductible (avg. $45)	N/A
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 80% after deductible
Inpatient Hospitalization	Plan pays 100% (referral required)	Plan pays 100% after deductible	$300 copay, then plan pays 80% after deductible
Outpatient Surgery	Plan pays 100% (referral required)	Plan pays 100% after deductible	Plan pays 80% after deductible
Urgent Care	$20 copay (referral required)	Plan pays 100% after deductible	Plan pays 80% after deductible
Emergency Room	$100 copay (waived if admitted)	Plan pays 100% after in-network deductible	Plan pays 100% after in-network deductible
Network	BlueAdvantage HMO [ADV]	Participating Provider Organization [PPO]	

Medical, continued

	PPO Plan	
	In-Network	Out-Of-Network
Annual Deductible	$400 single $800 family	$400 single $800 family
Annual Out-of-Pocket Maximum (includes deductible)	$1,400 single $3,800 family	$2,400 single $6,800 family
Physician Services		
Primary Provider	$20 copay	Plan pays 70% after deductible
Specialist	$20 copay	Plan pays 70% after deductible
Virtual Visits	$20 copay	Not Available
Preventive Services	Plan pays 100%	Plan pays 70% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	$300 copay, then 70% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 70% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 70% after deductible
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Network	Participating Provider Organization [PPO]	

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans, administered by **Prime Therapeutics.**

	BAHMO Plan	BlueEdge HSA Plan		PPO Plan	
	Network Only	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Prescription Drug Deductible	Not Applicable	Prescriptions subject to medical plan deductible		Not Applicable	
Annual Out-of-Pocket Limit	$1,000 single $2,000 family	Combined with medical		$1,000 single $3,000 family	N/A
Pharmacy					
Generic	$10 copay	Plan pays 100% after deductible	Plan pays 100% after deductible	$10 copay	$10 copay, then plan pays 75%
Preferred Brand	$20 copay	Plan pays 100% after deductible	Plan pays 100% after deductible	$20 copay	$20 copay, then plan pays 75%
Non-preferred Brand	$35 copay	Plan pays 100% after deductible	Plan pays 100% after deductible	$35 copay	$35 copay, then plan pays 75%
Supply Limit	34 days	90 days	90 days	34 days	34 days
Mail Order					
Generic	$20 copay	Plan pays 100% after deductible	Not applicable	$20 copay then plan pays 100%	Not applicable
Preferred Brand	$40 copay	Plan pays 100% after deductible	Not applicable	$40 copay then plan pays 100%	Not applicable
Non-preferred Brand	$70 copay	Plan pays 100% after deductible	Not applicable	$70 copay then plan pays 100%	Not applicable
Supply Limit	90 days	90 days	Not applicable	90 days	Not applicable

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

VIRTUAL VISITS

PPO and HDHP/HSA members can video chat with a doctor from the comfort of their own homes, without an appointment. MDLIVE provides 24/7 access to U.S. board-certified physicians, for the fraction of the cost of an office visit. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. To register, visit mdlive.com/bcbsil.

This program is not available to HMO members.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

24/7 NURSELINE

PPO and HDHP/HSA members have access to BCBSIL's 24/7 Nurseline. Speak with a registered nurse at any time of day to help decide whether you should go to the ER, urgent care center, or make an appointment with your doctor. Common cases include allergies, asthma, dizziness, high fever, diabetes, a baby's nonstop crying, and much more. Plus, when you call, you can access an audio library of more than 1,000 health topics, with more than 500 topics available in Spanish. Call the number on the back of your ID card.

This program is not available to HMO members.

BLUE CARD

This program covers HMO members traveling outside of Illinois who need medical attention for a condition that is not an emergency. To find a contracting provider in the area in which you are traveling, call the BlueCard program toll-free at 800-810-BLUE (800-810-2583) or search the Blue Cross and Blue Shield Association's website at bcbs.com. You can then call the provider directly to make an appointment. You pay the applicable copayment at the time of service and don't need to submit claim forms.

GOING ABROAD?

PPO and HDHP/HSA members traveling outside the United States can call 800-810-2583 or call collect to 804-673-1177 for medical assistance services. BCBS has contracts with doctors and hospitals in more than 190 countries. An assistance coordinator, in conjunction with a medical professional, can arrange your doctor's appointment or hospitalization, if necessary.

BlueCross BlueShield of IL Value Added Benefits

As a member of BlueCross BlueShield of Illinois, you have access to many FREE resources that are included in your medical plan. Take advantage of all your health plan has to offer!

BLUE ACCESS FOR MEMBERS℠

Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the BCBSIL secure member website, Blue Access for Members℠ (BAM). With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits
- Locate in-network providers
- Request a new ID card - or print a temporary one

It's easy to get started! Go to www.bcbsil.com/member and register using the information on your ID card. Also download the free mobile app to have access when you're on the go, plus receive alerts for taking and re-filling prescriptions!

MAIL ORDER PRESCRIPTIONS

Save time and money by getting eligible prescriptions, such as maintenance medications, through mail order. AllianceRx Walgreens Prime administers the mail order program.

SPECIAL BEGINNINGS®

Special Beginnings® is a maternity program that can help expectant mothers better understand and manage their pregnancy. Available at no cost, this maternity program supports you from early pregnancy until six weeks after delivery through pregnancy risk factor identification and assistance in managing those risks, educational material (a book and online resources each week of your pregnancy), and personal telephone contact and coordination of care with your physician. Enrollment is easy and confidential. Call (888) 421-7781.

BLUE365 DISCOUNTS

As a member, you have access to discounts on health and wellness products and services from top retailers that are not covered by insurance. Some ongoing deals include discounts on eyewear, hearing aids, dental products, weight-loss programs, gym memberships and apparel, and much more. Best of all, many of the discounts extend to family members!

Register at www.blue365deals.com/BCBSIL.

WELL ONTARGET℠

The Well onTarget member wellness portal provides you with tools to help you set and reach your wellness goals. Take a Health Assessment, track your health, and access self-directed courses and materials. Not only does the program help you meet your wellness goals, but you earn Blue Points that are redeemable in the online shopping mall. Sync your fitness tracker with Well onTarget for easy integration and get rewarded for activities you're already doing!

FITNESS PROGRAM

Available exclusively to members and their covered dependents age 16+. (Dependents age 16-17 can join but must be accompanied by a parent who is a member) Membership is flexible and affordable – no long-term contract is required. There is a one-time enrollment fee which varies depending on the tier you enroll in (4 tiers – Base, Core, Power and Elite). Members now have access to studio classes that are offered on a pay as you go status. You are also rewarded Blue Points for joining the program and regular visits each week.

Health Savings Account (HSA)

Do you want to save money on taxes? A Health Savings Account is a tax-advantaged, portable (you own it!) savings account that is offered if you enroll in our BlueEdge HSA Medical Plan.

You (optional) and Oak Lawn Community HS Dist. 229 contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money that you don't spend grows year after year and can be used in the future, even after you retire. AmeriFlex administers this account.

ACCOUNT CONTRIBUTIONS

	Company Contributes	You Can Contribute
Employee	$500	$3,600 less employer contribution
Employee + Family	$1,000	$7,200 less employer contribution
Catch Up Contributions		An additional $1,000 per year at age 55+

USING YOUR MONEY

You can use your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). In general, your HSA can be used for these expenses:

- Medically necessary expenses that are not covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Over-the-counter (OTC) medications prescribed by your doctor
- Certain medical equipment

When possible, use your HSA debit card to pay for expenses. Make sure that you keep records of your receipts and any OTC prescriptions in case the IRS requests them.

ELIGIBILITY

You are not eligible to open or contribute to an HSA account if you are:

- Covered by a non-high deductible health plan
- Enrolled in a regular healthcare flexible spending account (you or your spouse count)
- Covered under Medicare, Medicaid or Tricare
- Someone else's tax dependent

Non-Qualified Expenses

If you use HSA funds for non-qualified expenses before age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only. Visit irs.gov/publications/p502 for details.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year. **AmeriFlex** administers this program.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Expenses must be incurred between 1/1/21 and 3/15/22 and submitted no later than 3/31/22.
- Elections cannot be changed during the plan year, unless you have a qualified change in status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election. The plans include a 2 ½ month grace period.
- FSA funds can be used for eligible expense incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on the Oak Lawn Community HS Dist. 229 health plan.
- Keep your receipts as proof that your expenses were eligible for IRS purposes.

TAX-FREE HEALTHCARE FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $2,750 per year.

If you are enrolled in the BlueEdge HSA Medical Plan, you can participate in our Limited Purpose FSA which covers out-of-pocket vision and dental expenses ONLY.

TAX-FREE DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Oak Lawn Community HS Dist. 229 gives you a choice of dental plans. Coverage is provided by BlueCross BlueShield of Illinois.

	Dental HMO Plan	Dental PPO Plan	
	Network Only; primary dentist required	In-Network	Out-Of-Network
Calendar Year Deductible	None	$100 single $200 family	$100 single $200 family
Annual Plan Maximum	Unlimited	$2,000 per individual	$2,000 per individual
Diagnostic and Preventive	See copay schedule	Plan pays 100%	Plan pays 100%
Basic Services	See copay schedule	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services	See copay schedule	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontic Services			
Orthodontia	$1,500 copay	Plan pays 50% after deductible	Plan pays 50% after deductible
Lifetime Maximum	Unlimited	$1,000	$1,000
Dependent Children	Covered to age 19	Covered to age 26	Covered to age 26
Adults	Covered	Not covered	Not covered
Network	BlueCare Dental HMO	BlueCare Dental PPO	

Vision

Oak Lawn Community HS Dist. 229 offers a vision plan that allows you to choose from a network of independent optometrists, ophthalmologists, opticians throughout the country. Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through BlueCross BlueShield of Illinois.

	Vision Plan	
	In-Network	Out-Of-Network
Examination Benefit	$10 copay	$30 allowance
Frequency	Once every 12 months from last date of service	
Eyeglass Lenses		
Single Vision Lens	$10 copay	$25 allowance
Bifocal Lens	$10 copay	$40 allowance
Trifocal Lens	$10 copay	$55 allowance
Frequency	Once every 12 months (in lieu of contacts) from last date of service	
Frames Benefit	$150 allowance; 20% off balance	$75 allowance
Frequency	Once every 24 months from last date of service	
Contacts		
Conventional	$150 allowance; 15% off balance	$120 allowance
Disposable	$150 allowance	$120 allowance
Frequency	Once every 12 months (in lieu of glasses) from last date of service	
Laser Vision Correction	LASIK and PRK Vision Correction Procedures are available from U.S. Laser Network. In-network benefits include 15% off the retail price or 5% off the promotional price.	
Network	EyeMed's SELECT network	
Member Perks	Hearing care discounts through Amplifon, savings through Glasses.com and ContactsDirect.com	

Other Programs

EMPLOYEE ASSISTANCE PROGRAM

Perspectives

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Perspectives, LTD can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's **free**.

Help is available 24/7, 365 days a year by telephone at 800-456-6327. There is also a mobile app, called Spark. Other resources are available online at https://features.perspectivesltd.com/login.aspx

Username: Oak503 / Password: perspectives

In-person counseling is also be available, depending on the type of help you need.

Cost of Coverage

You and Oak Lawn Community HS Dist. 229 share in the cost of coverage for medical, dental and vision coverage. You pay before federal, state, and social security taxes are withheld, so you pay less in taxes.

BAHMO Medical Plan	Your Cost (per month)
Employee Only	$93.65
Employee + Spouse	$310.47
Employee + Child(ren)	$297.94
Employee + Family	$460.96
BlueEdge HSA Medical Plan	**Your Cost (per month)**
Employee Only	$94.76
Employee + Spouse	$314.17
Employee + Child(ren)	$301.49
Employee + Family	$466.45
PPO Medical Plan	**Your Cost (per month)**
Employee Only	$111.48
Employee + Spouse	$369.61
Employee + Child(ren)	$354.69
Employee + Family	$548.76
Dental HMO Plan	**Your Cost (per month)**
Employee Only	$4.85
Employee + Spouse	$16.03
Employee + Child(ren)	$17.65
Employee + Family	$26.62
Dental PPO Plan	**Your Cost (per month)**
Employee Only	$5.94
Employee + Spouse	$24.22
Employee + Child(ren)	$23.24
Employee + Family	$35.96
Vision Plan	**Your Cost (per month)**
Employee Only	$0.92
Employee + Spouse	$3.00
Employee + Child(ren)	$3.16
Employee + Family	$4.65

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	BlueCross BlueShield of IL	HMO: (800) 982-2803 HSA & PPO: (800) 458-6024	www.bcbsil.com	HMO: B92875 HSA: PH4925 PPO: PH4920
Pharmacy	Prime Therapeutics	800.423.1973	www.myprime.com	992875
Health Savings Account	AmeriFlex	(888) 868-3539	www.myameriflex.com	AMFOAKLAW
Flexible Spending Accounts	AmeriFlex	(888) 868-3539	www.myameriflex.com	AMFOAKLAW
Dental	BlueCross BlueShield of IL	HMO: (800) 323-7201 PPO: (800) 367-6401	www.bcbsil.com	HMO: D92875 PPO: 099287
Vision	BlueCross BlueShield of IL	(800) 348-4512	www.bcbsil.com	F022824
Employee Assistance Program (EAP)	Perspectives, LTD	(800) 456-6327	www.perspectivesltd.com	Username: Oak503 Password: perspectives

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available on www.olchs.org/about/business-office/insurance/ and include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.
- Patient Protection Notice
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).
- HIPAA Notice of Privacy Practices
  Describes how health information about you may be used and disclosed.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

CURRENT PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on www.olchs.org/about/business-office/insurance/ and include:

Summary Plan Descriptions

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The SBCs are available on www.olchs.org/about/business-office/insurance/

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Kathie Simpson at 708-741-5604.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Oak Lawn Community HS Dist. 229 Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Notes

This Benefits Guide only highlights the benefits available. For a more complete description, see the Plan Certificates. If any conflict should arise between this Guide and the Plan Document, the Plan Document will govern in all cases.

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