Open Enrollment Guide: 2021 Plan Year

Open Enrollment: October 23 – November 10, 2020

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

Have you talked to alex®?

Walk through your options at www.myalex.com/districtu46/2021

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 brought in 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.

ALEX is available from any computer or device with an internet connection. If you have any questions about how anything works, ALEX can walk you through them.

Start a conversation with ALEX today. Visit www.myalex.com/districtu46/2021.

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:

Monday, October 26, 2020
3:30 P.M. – 4:30 P.M.
https://zoom.us/j/99023990142?pwd=UnRxY0psZEFPSURiVGJlQ283QWJiZz09

Tuesday, November 3, 2020
12:00 P.M. – 1:00 P.M.
https://zoom.us/j/99904048061?pwd=emJpMWhyZVVEcnVOZmYvY2pIcG51dz09

Thursday, October 29, 2020
4:00 P.M. – 5:00 P.M.
https://zoom.us/j/91257646488?pwd=MjR6SzBjeTNDWHdGVExGYkNUQmI4Zz09

A RECORDED VERSION OF THESE MEETINGS WILL BE POSTED ON THE BENEFITS HOME PAGE IF YOU CANNOT ATTEND A LIVE MEETING

October 23, 2020

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 2021 benefit plans on October 23 and ask that you submit your elections by November 10, 2020. New enrollments and changes become effective January 1, 2021. Take time to **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 three available medical options to see which plan is the best fit for you.

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 humor. Visit ALEX at www.myalex.com/districtu46/2021 if you have questions about your benefit plan options. Find out why 94 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.

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 eligible employees must log into Munis Self Service to review their elections. All benefit eligible employees **must log in** to make their elections or waive coverage. If you waived coverage for 2020, you will need to waive coverage again for 2021. ***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.***

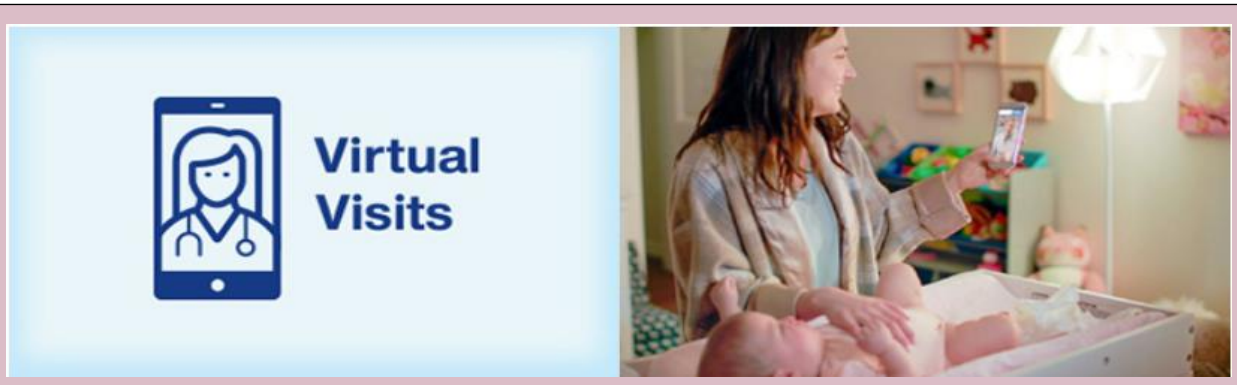
I encourage you to carefully review and consider the information provided in the 2021 Open Enrollment Guide. Should you have any questions, please contact our Benefits Department at benefits@u-46.org.

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
Superintendent

School District U-46



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 Friday, October 23, 2020 and ends at midnight (CST) on Tuesday, November 10, 2020.

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 Insurance
- Voluntary 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 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.

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 2020 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 give it to help you with making 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 www.myalex.com/districtu46/2021.

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

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. If you cannot remember your password or the answer to your security question, **please contact the Help Desk at x4295 or HelpDesk@u-46.org, and they can reset your password.**
   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 11/10/2020" to start the enrollment process.
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.

Changes for the 2021 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

All Plans

COVID -19 Testing - Coverage for COVID-19 diagnostic testing will be covered at 100%, with no employee cost sharing, for the duration that COVID-19 is declared a public health emergency. Currently, the public health emergency is stated to last through January 20, 2021, unless ended earlier or extended by the Health and Human Services secretary.

COVID-19 Treatment- Treatment of COVID-19 will be covered at the applicable cost sharing and deductible based on the terms of each medical plan.

Kaia Health (Digital Musculoskeletal Resources) - Effective January 1, 2021, the District will offer Kaia Health, a digital, multimodal program to safely and effectively help both the body and brain cope with musculoskeletal conditions. See page 5 for a detailed description of Kaia Health.

Nurseline Available Through Customer Service - UnitedHealthcare's NurseLine service will be discontinued beginning in 2021. As a replacement, we encourage members to call the customer service number on their insurance card.

PPO Plan - No changes were made to the PPO Plan for 2021.

Gold + HSA Plan - No changes were made to the Gold + HSA Plan for 2021.

Silver + HSA Plan - No changes were made to the Silver + HSA Plan for 2021.

The Pharmacy Program

Effective January 1, 2021, drug manufacturer coupons or copay cards will not count towards a participant's deductible or out-of-pocket maximum.

The Wellness Program *(for those enrolled in a medical option)*

No changes were made to the wellness program for 2021. However, the diabetes A1c and total cholesterol will decrease from 7.0 in 2020 to 6.6 in 2021 for A1c and from 220 in 2020 to 215 in 2021 for total cholesterol based on the scale adopted last year.

Year	A1c	Total Cholesterol
2020	7.0	220
2021	6.6	215
2022	6.3	210
2023	6.0	205

Health Care Flexible Spending Account (FSA)

The 2021 FSA maximum contributions and annual carryover amount were increased.

1. The maximum Heath Care FSA contribution increased from $2,700 to $2,750 for 2021.
2. The FSA carryover amount increased from $500 to $550 of unused 2020 Health Care FSA funds that may be carried over to the year 2021.

Voluntary Additional Medical Coverage

(for those eligible to enroll in a medical option)

Critical Illness Program - No changes for 2021.

Hospital Indemnity Program - No changes for 2021.

Introducing Kaia (Digital Musculoskeletal Resources)

Effective January 1, 2021, the District will offer Kaia, a digital, multimodal program to safely and effectively help both the body and brain cope with musculoskeletal conditions.

What is Kaia?

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 plans 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**

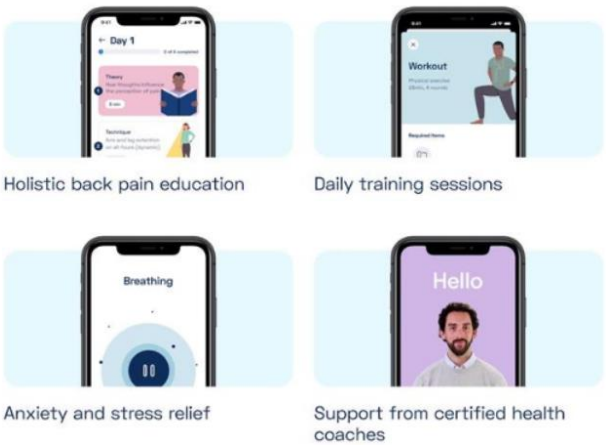
  15 minutes of daily exercises using motion coach

- **Mindfulness and stress relief**

  Tailored mindfulness and relaxation exercises

- **Access to Kaia's certified coaches**

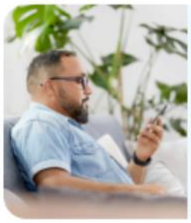
  Dedicated accredited coaches support you every step of the way through one on one Coaching Sessions over the phone or using Kaia Chat



Holistic back pain education | Daily training sessions

Anxiety and stress relief | Support from certified health coaches

What makes Kaia different?

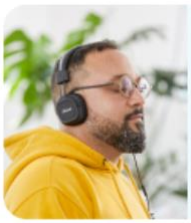


Gold-standard therapy, in your pocket.

Kaia makes use of therapy methods that are proven to reduce pain without medication or surgery.

Flexible enough for any schedule

Complete your program whenever and wherever it suits you – in as little as 15 minutes per day.



Personalized exercise programs

Complete your own custom program, created especially for your pain type, mobility and skill level.

Next Steps

No action is needed at this time. Instructions to access Kaia will be provided before the program launches on January 1, 2021.

2021 Medical Plan Options

District U-46 offers three medical options which are self-funded medical programs. 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). All three plans are administered by UnitedHealthcare on behalf of the District.

The three 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 2021.** 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 with 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, 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, 2021.**

All of the plans offer the same services and benefits. The difference among the plans relate to the cost-sharing – deductibles, coinsurance, and copays.

- All three plans offer the same network of providers.
- All three 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.
- Each plan has 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).
- Each plan has 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 for after-deductible benefits to 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.
- Each plan has 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 three medical options. Specific cost sharing is described in the summary plan description for the medical options.

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 12 for more information.

Which Plan has the highest benefit level?

2019 Health Plan	Benefit Level Percentage (Actuarial Value)	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
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

[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 ext. 5026 or ext. 5671, 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
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**	30%	$150	$300	30%	$85	$125	30%	$150	$300

[3] Not all prescriptions are covered. For a list of exclusions, please go to https://www.u-46.org/cms/lib/IL01804616/Centricity/Domain/6447/U46%202021%20RX%20Exclusions.pdf

[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, see https://www.u-46.org/cms/lib/IL01804616/Centricity/Domain/6447/2021%20Preventive%20Medication%20List.pdf

[6] Effective, January 1, 2021, drug manufacturer coupons or copay cards will 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 ext. 5026 or ext. 5671, 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	$5,064	$4,304	$760	$29.23	$40.00
Employee plus spouse	$10,381	$8,824	$1,557	$59.88	$81.95
Employee plus children	$8,710	$7,403	$1,307	$50.27	$68.79
Family	$14,433	$12,268	$2,165	$83.27	$113.95
Dependent Veteran Child	$5,064	$0	$5,064	$194.77	$266.53
PPO Plan					
Employee only	$9,959	$8,465	$1,494	$57.46	$78.63
Employee plus spouse	$20,417	$17,354	$3,063	$117.81	$161.21
Employee plus children	$17,130	$14,560	$2,570	$98.85	$135.26
Family	$28,384	$24,126	$4,258	$163.77	$224.11
Dependent Veteran Child	$9,959	$0	$9,959	$383.05	$524.17
Gold + HSA					
Employee only	$10,314	$8,767	$1,547	$59.50	$81.42
Employee plus spouse	$21,144	$17,972	$3,172	$122.00	$166.95
Employee plus children	$17,740	$15,079	$2,661	$102.35	$140.05
Family	$29,395	$24,986	$4,409	$169.58	$232.05
Dependent Veteran Child	$10,314	$0	$10,314	$396.69	$542.84
Dental Plan					
Employee only	$663	$663	$0	$0.00	$0.00
Employee plus spouse	$1,359	$663	$696	$26.76	$36.63
Employee plus children	$1,140	$663	$477	$18.36	$25.12
Family	$1,889	$663	$1,226	$47.16	$64.53
Dependent Veteran Child	$663	$0	$663	$25.50	$34.89
Vision Plan					
Employee only	$92	$46	$46	$1.76	$2.41
Employee plus spouse	$174	$87	$87	$3.34	$4.57
Employee plus children	$182	$91	$91	$3.52	$4.81
Family	$268	$134	$134	$5.17	$7.07
Dependent Veteran Child	$92	$0	$92	$3.52	$4.81

Voluntary Critical Illness Insurance

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 the purposes of health savings accounts. Watch an informational video here: https://vimeo.com/user35567318/review/116998794/430344eb4c

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. 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 $5,000 to a maximum of $30,000 in $5,000 increments.
- Spouse –Choose from a minimum of $5,000 to a maximum of $30,000 in $5,000 increments, not to exceed 100% of approved employee amount.
- Dependent child(ren) –25% of approved employee amount up to a maximum of $7,500
- Lifetime Maximum Benefit – 1,000% of Insurance Amount
- Subsequent Occurrence Benefit (different illness) – 100% of benefit if diagnosed 3 months or later
- Recurrence Benefit (same illness) – 50% if diagnosed 6 months or later
- Pre-Existing Condition Limitation – A pre-existing condition is any sickness or injury, whether specifically diagnosed or not, for which an insured received treatment, consultation, care or services, including diagnostic procedures, or for which he/she took prescription drugs or medicines, during the look back period (12 months) before the individual effective date of coverage (or the effective date of an increase in coverage). Benefits (or an increased benefit) would not be payable due to a pre-existing condition unless the Critical Illness is diagnosed after the coverage period (12 months) from the insured's effective date of coverage (or effective date of an increase).
- Exclusions – Certain exclusions may apply. See Certificate of Insurance for a full list.

Features

DIAGNOSIS ADULT	BENEFIT
Alzheimer's	50%
Benign Brain Tumor	100%
Carcinoma in Situ – Partial Benefit	25%
Coma	100%
Coronary Disease – Partial Benefit	25%
Heart Attack	100%
Life Threatening Cancer	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Major Organ Failure	100%
Motor Neuron Disease (ALS; Lou Gehrig's)	100%
Occupational Hepatitis	100%
Occupational HIV	100%
Paralysis	100%
Severe Brain Damage	100%
Skin Cancer – Partial Benefit	15%
Stroke	100%
CHILD DIAGNOSIS	**BENEFIT**
Cerebral Palsy	100%
Cleft Lip or Palate	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Type 1 Diabetes	100%

Guaranteed Issue

- Employee: $30,000
- Spouse: $30,000
- Child: All child amounts are guaranteed issue

Benefit Reduction Due to Age *(applicable to employee/spouse coverage)*

- Age 70
- Original Benefit Reduced to: 50%

Premium: Monthly Rate per $1,000 Coverage

	Age Band	Premium Rate
Employee and Spouse • Age at last birthday as of January 1st • Spouse age is the same as employee when determining premium	0-29	$0.22
	30-39	$0.42
	40-49	$0.89
	50-59	$1.79
	60-69	$3.41
	70+	$8.25
Children (one rate for all eligible children)	Any age	$0.40

At least 10 employees must elect coverage for the District to offer this benefit.

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

Voluntary Hospital Indemnity Insurance

Coverage

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: https://vimeo.com/203496815/3b626683ee

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. 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

Hospital Room & Board Benefits	Per Day Benefit *(up to 180 Daily Benefits Per Plan Year)*	$100
Hospital Critical Care Benefits *(Paid in addition to Room & Board Benefit)*	CCU Benefits Per Day *(up to 30 Daily Benefits Per Plan Year)*	$50
Hospital Admission Benefit	*One Daily Benefit Per Plan Year*	$250

Features`

- Guaranteed issue; no medical questions
- No pre-existing conditions exclusions during initial enrollment period
- A 3 month look back/12 month forward pre-existing condition applies for enrollment after first becoming eligible
- Mental & Nervous and Substance Abuse treated same as any other hospital admission
- No deductibles
- HSA compatible
- Eligible for continuation of coverage
- HIPAA privacy compliant

Exclusions

Benefits will not be paid for any loss caused by: suicide; war; assault/felony; dental care except hospitalizations for the care of sound, natural teeth and gums required on account of accidental injury that happens while covered, and that occur within 6 months of the accident; hospitalizations that occur while outside the United States of America; or care or treatment rendered in connection with cosmetic surgery, except hospitalizations for cosmetic surgery needed for breast reconstruction following a mastectomy or for an accident that happens while covered. The cosmetic surgery needed for an accidental injury must be performed within 90 days of the accident.

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.

Premiums

Coverage Level	Monthly Premium
Employee Only	$ 7.52
Employee plus Spouse	$17.00
Employee plus Children	$14.08
Employee plus Family	$21.26

At least 5 employees must elect coverage for the District to offer this benefit.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. 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. The contributions you make to an HSA are not subject to any federal or Illinois income or employment taxes when contributed, 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 the 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 2021:

	Silver + HSA	Gold + HSA
Single Coverage		
Legal Contribution Maximum*	$3,600	$3,600
District Contribution**	$480	$600
Your Contribution Maximum	**$3,120**	**$3,000**
Family Coverage		
Legal Contribution Maximum*	$7,200	$7,200
District Contribution	$960	$1,200
Your Contribution Maximum	**$6,240**	**$6,000**

**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.

Active Enrollment. If you are not receiving benefits from Social Security or the Railroad Retirement Board at least 4 months before attaining age 65, you will need to sign up for 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.

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.

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.

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]			
	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 2021 and may be subject to change for subsequent years.

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. The current fund offering can be found at: https://www.optumbank.com/health-accounts/hsa/investment-services.html

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

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. (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 2020 Health Care FSA balance to the next year. Be sure to consider the rollover when electing your 2021 Health Care FSA deduction amounts. *You cannot rollover FSA funds from 2020 into 2021 if you elect the Gold + HSA or Silver + HSA health plans for 2021. 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. You must submit your 2020 dependent care claims by March 15, 2021, or any remainder in your 2020 Dependent Care FSA will be forfeited. $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.

FSA Worksheet

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

- Only PPO 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 2020 and 2021 in order to have a Health Care FSA's funds roll over from 2020 to 2021. If you enroll in the Gold or Silver HDHPs for 2021 and have FSA funds left from 2020, 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.

This worksheet can be used to estimate your FSA contributions.

Health Care Flexible Spending Account Expenses not covered by insurance may include:	
Deductibles, coinsurance or copayments	$
Dental care (exams, fillings, crowns)	$
Hearing care (exams, hearing aids, batteries)	$
Infertility treatment	$
Insulin and diabetic supplies	$
Prescription drugs (e.g., cholesterol medications)	$
Transportation expenses (to receive medical care)	$
Vision care (exams, contacts, eyeglasses, laser surgery)	$
Weight loss program (done at doctor's direction to treat an existing disease)	$
Wheelchairs	$
Annual Health Care Flexible Spending Account Election	$

The District's Wellness Program

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 a bonus program.

Eligibility

An employee and spousal dependents who participate in one of the District's base medical options are eligible to participate in the District's Wellness Program. A person may not have coverage as both an employee and as a dependent.

United Healthcare's Rally

District U-46 uses UnitedHealthcare's wellness tracking tool, 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, we make it 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?

The Rally portal is where your progress for qualifying for the Wellness Incentive is tracked. For the 2021 plan year, the wellness tracking period starts January 1, 2021 and ends on December 31, 2021. 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 Program		
Awareness	• Health Survey (Required)	**30%**
	• Biometric Screening	**10%**
	• Any of the following:	**20%**
	◦ BMI ≤ 27.5 or 2 pt. improvement	
	◦ A1c ≤ 6.6	
	◦ Total Cholesterol ≤ 215	
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%**
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 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 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 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:

- 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.

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 amount 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.

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 2020, 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 2021. If you were not enrolled in 2020, you will not be enrolled for 2021 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 2021

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 three medical options and choose not to enroll in the vision option. Or, you may choose not to enroll in of the three 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 three 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 three 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 2020, you must click the "No Changes" button next to the dental section during Open Enrollment to retain your coverage for 2021. If you were not enrolled in 2020, you will be automatically enrolled in single dental coverage for 2021 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 at: http://dbp.optum.com/content/dental-benefits-provider/en.html.html. 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 2021

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 increased by approximately 1.0% 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	$663	$0	$0.00	$0.00
EE + Spouse	$1,359	$696	$26.76	$36.63
EE + Children	$1,140	$477	$18.36	$25.12
Family	$1,889	$1,226	$47.16	$64.53
Dep Vet Child	$663	$663	$25.50	$34.89

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 Reliance Standard Life Insurance Company (RSLI). 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 Services. Because rates are based on your age as of January 1, 2021, 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. [The benefit is limited to $1,000 for children between 14 days and 6 months old.] 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 you increase your existing coverage by more than $10,000 per year or 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

You will be required to provide evidence of insurability, also known as proof of good health, to receive supplemental life insurance if:

- You did not elect supplemental life insurance last year or within 31 days of being hired and you wish to enroll for more than $10,000 of coverage for yourself and/or for your spouse.
- You enrolled in supplemental life insurance last year, but you would like to increase your existing coverage to an amount greater than $10,000 for yourself and/or your spouse.
- The $10,000 increase of coverage raises coverage at or above the guaranteed issue amount of $250,000 for employees and $50,000 for spouse.

The evidence of insurability form may be completed electronically through PowerForm using the following link – https://na3.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=c8ef3041-c50a-44a1-a59a-6fc1e7785f1a&env=na3&acct=05544466-1ed5-4fdc-98ef-48e0f493367c&v=2

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, 2021	Rate per Month Per $10,000
<30	$0.78
30-34	$0.78
35-39	$0.89
40-44	$0.98
45-49	$1.24
50-54	$1.47
55-59	$2.04
60-64	$3.42
65-69	$5.03
70-74	$9.17
75-79	$15.04
80+	$40.57
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 Bank

- 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 (Reliance Standard Life Insurance)

- Phone: 800-351-7500
- Web: www.reliancestandard.com

School District U-46 Benefits Team

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

The 2021 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, 2021. 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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