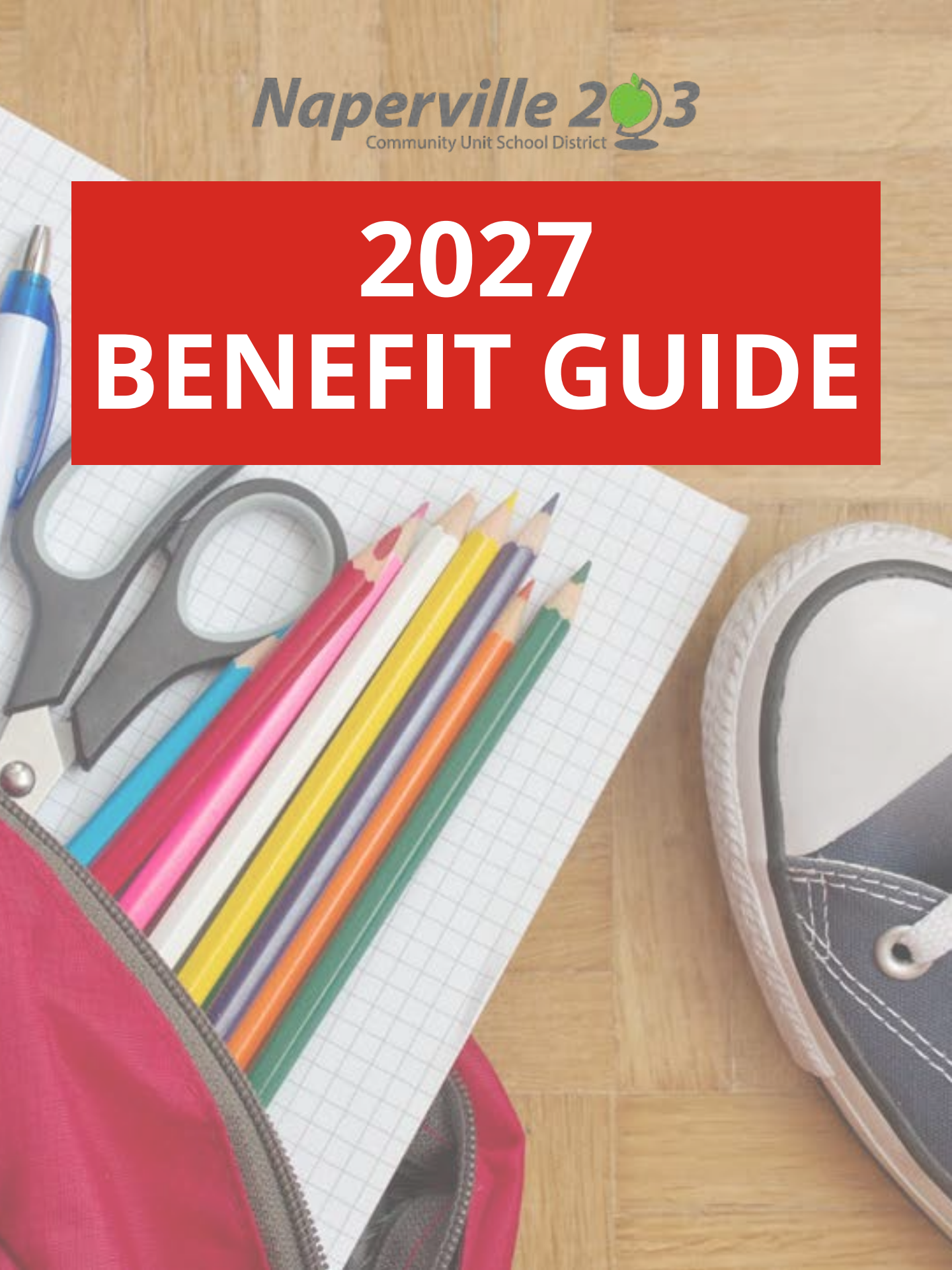
Naperville 203
Community Unit School District

2027 BENEFIT GUIDE



Quick Reference Guide to Employee Benefits

Accessing Employee Benefit Information - Employee Benefits Guide, Enrollment Information, Forms…
Go to your employee benefit account OR go to D203 website and select Department Services → Human Resources → Health & Well-Being 203

Accessing YOUR Employee Benefits Account
Go to www.naperville203.org → select I am a…. → Staff Member → select District Resource Center → click on the Employee Benefits Icon (smaller icon) → log in to your account (Company Key: D203)

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

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

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

Consistency Rule
Benefit eligibility and plan offerings are applied consistently to employees who fall within the same eligible employee class. This helps ensure employees in similar circumstances are treated the same under the plan's established rules.

Considering a Leave of Absence
Contact your Human Resources Generalist

Changing Personal Information - Name, Address, Phone, Emergency Contact
Contact your Human Resources Generalist

Address, Phone, Emergency Contact: Go to www.naperville203.org → select I am a…. →Staff Member → select District Resource Center→ click on Human Resources → select D203 Staff Resource Library → Select Address or Name Change Process

Annual Benefits Enrollment
Starts mid-October with a January 1 effective date

Wellness Program
Naperville has a wellness program through Marathon Health that you can participate in to stay healthy and help keep your medical premiums lower.

Benefits Plan Carriers

Medical	BlueCross BlueShield of Illinois
Prescription Drugs	Prime Therapeutics
Dental	Guardian
Vision	Guardian
Health Care Flexible Spending Account	Inspira Financial
Dependent Care Flexible Spending Account	Inspira Financial
Health Savings Account	Lively
Employee Assistance Program	ComPsych
Telehealth Medical	Teladoc
Telehealth Behavioral Health	Teladoc
Basic Life Insurance	Guardian
Voluntary Life, Critical Illness, Accident Insurance	Guardian

Near site clinic on Ogden Ave for Naperville 203 medical participants only! The clinic is called Priority Care – powered by Marathon Health. See page 12 for more information.

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Hello!

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

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

Effective January 1, 2027, medical benefits will renew with BCBS. and all ancillary lines will remain with Guardian.

Our near-site clinic, Priority Care, is available for all members enrolled in medical to utilize for preventive, acute, mental health and more. See more details in the guide.

This guide provides **highlights** of your benefits programs. Keep this guide with your other important papers so you can refer to it as needed. For a complete description of your benefits, please refer to your benefit plan certificates, located on your employee benefits account.



Enrollment

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

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

- Change in legal marital status (marriage, divorce, death of spouse)
- Change in employment status for you, your spouse, or a dependent that affects eligibility
- Birth, adoption, or placement for adoption of a child
- Death of a spouse or dependent
- Change in a dependent's eligibility

Benefit changes due to a qualifying life event must satisfy a consistency rule. That is, any change must be consistent with the qualifying event. Example: If you get a divorce, you can remove your spouse but cannot add existing dependents who were not on your plan.

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

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

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

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

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

Medical/Prescription Drug Plan

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

District 203 offers four choices for medical/prescription plans through BlueCross BlueShield of Illinois. Each of the plans uses a specific BCBS network. To take full advantage of each plan, it is important to confirm in-network status with BCBSIL prior to services being rendered. Visit BCBSIL.com or call 1.800.458.6024 to check for in-network providers for your chosen medical plan

Blue Choice Options (BCO) Plan: This 3-tier PPO plan features a low deductible, co-insurance, and copays for office visits and prescriptions. This plan has two in-network tiers. Tier 1 utilizes the Blue Choice Options (BCO) network and offers the highest level of benefits. Tier 2 utilizes the larger Participating Provider Organization (PPO) but has a slightly higher deductible and out-of-pocket costs. Tier 1 and Tier 2 cross-feed deductible and out-of-pocket costs. If you use Tier 2 benefits after meeting the deductible and/or out-of-pocket costs on Tier 1, Tier 1 costs will count towards your Tier 2 total.

Blue Choice Select (BCS) Plan: This plan features a low deductible and co-insurance with copays for office visits and prescriptions along with the claims savings that come from using a narrower network. This plan utilizes the Blue Choice Select (BCS) network which is a smaller network of providers but features greater average discounts and lower negotiated in-network fees.

Blue Choice Options (BCO) HDHP: This 3-tier HDHP features a higher deductible, no copays for office visits and prescriptions, and is a health savings account (HSA) eligible plan. This plan has two in-network tiers. Tier 1 utilizes the Blue Choice Options (BCO) network and offers the highest level of benefits. Tier 2 utilizes the larger Participating Provider Organization (PPO) network but has a slightly higher deductible and out-of-pocket costs. Tier 1 and Tier 2 cross-feed deductible and out-of-pocket costs. If you use Tier 2 benefits after meeting the deductible and/or out-of-pocket costs on Tier 1, costs will count towards your Tier 2 total. The annual District contribution to an employee's active Lively HSA is $1,500 for individual coverage and $3,000 for family coverage.

Blue Choice Select (BCS) HDHP: This plan features a higher deductible, no copays for office visits and prescriptions and health savings account (HSA) eligibility along with the claims savings that come from using a narrower network. This plan utilizes the Blue Choice Select (BCS) network which is a smaller network of providers but features greater average discounts and lower negotiated in-network fees. The annual District contribution to an employee's active Lively HSA is $1,500 for individual coverage and $3,000 for family coverage.

Medical/Prescription Drug Plan

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

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

BlueCross BlueShield of Illinois' Utilization Management Programs

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

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

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

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

BCBS Medical/Prescription Drug Plan

BlueCross BlueShield of Illinois – Blue Choice Options (BCO) Plan **Group Number 309000**

Plan Features			
	In-Network - Tier 1 Blue Choice Options (BCO Network)	**In-Network - Tier 2 Participating Provider Organization (PPO Network)**	**Out-of-Network**
Calendar Year Deductible			
Individual	$1,500	$2,000	$3,000
Family	$1,500 x 2 = $3,000	$2,000 x 2 = $4,000	$3,000 x 2 = $6,000
Medical Out-of-Pocket (excludes Deductible)			
Individual	$1,500	$2,000	$3,000
Family	$1,500 x 2 = $3,000	$2,000 x 2 = $4,000	$3,000 x 2 = $6,000
Total Medical Out-of-Pocket Maximum			
Individual	$3,000	$4,000	$6,000
Family	$3,000 x 2 = $6,000	$4,000 x 2 = $8,000	$6,000 x 2 = $12,000
Prescription Out-of-Pocket Limit			
Individual	$3,000	$3,000	$3,000
Family	$6,000	$6,000	$6,000
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100%, Deductible Waived	100%, Deductible Waived	50% after Deductible
Office Visit	$30 Copay	$45 Copay	50% after Deductible
MARATHON PRIORITY CARE CLINIC OFFICE VISIT	**$0 Copay**	**$0 Copay**	**NA**
Inpatient Hospital Services	90% after Deductible	70% after Deductible	50% after Deductible
Outpatient Surgical Care	90% after Deductible	70% after Deductible	50% after Deductible
Outpatient Lab & X-ray	100% Deductible Waived	100% Deductible Waived	50% after Deductible
Emergency Room (Copay waived if admitted)	$500 Copay then 90% Deductible Waived	$500Copay then 90% Deductible Waived	$500 Copay then 90% Deductible Waived
Ambulance	90% after Deductible	70% after Deductible	50% after Deductible
Durable Medical Equipment	90% after Deductible	70% after Deductible	50% after Deductible
Rehabilitation Services	90% after Deductible	70% after Deductible	50% after Deductible
Mental Health/Substance Abuse Inpatient	90% Deductible Waived	70% Deductible Waived	50% after Deductible
Mental Health/Substance Abuse Outpatient	90% after Deductible	70% after Deductible	50% after Deductible
Mental Health/Substance Abuse Office Visit	$30 Copay	$45 Copay	50% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***		
Level One	$5 / $7.50 Copay	$5 / $7.50 Copay	$5 Copay + 25%
Level Two	$30 / $45 Copay	$30 / $45 Copay	$30 Copay + 25%
Level Three	$50 / $75 Copay	$50 / $75 Copay	$50 Copay +25%
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	$0 Copay / Not Applicable	$0 Copay / Not Applicable	Not Applicable

BCBS Medical/Prescription Drug Plan

BlueCross BlueShield of Illinois – Blue Choice Select (BCS) Plan **Group Number OMB995**

Plan Features		
	In-Network Blue Choice Select (BCS Network)	**Out-of-Network**
Calendar Year Deductible		
Individual	$500	$1,000
Family	$500 x 2 = $1,000	$1,000 x 2 = $2,000
Medical Out-of-Pocket (excludes Deductible)		
Individual	$1,000	$2,000
Family	$1,000 x 2 = $2,000	$2,000 x 2 = $4,000
Total Medical Out-of-Pocket Maximum		
Individual	$1,500	$3,000
Family	$1,500 x 2 = $3,000	$3,000 x 2 = $6,000
Prescription Out-of-Pocket Limit		
Individual	$3,000	$3,000
Family	$3,000 x 2 = $6,000	$3,000 x 2 = $6,000
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100% Deductible Waived	100% Deductible Waived
Office Visit – PCP / Specialty	$30 Copay / $50 Copay	60% after Deductible
MARATHON PRIORITY CARE CLINIC OFFICE VISIT	**$0 Copay**	**NA**
Inpatient Hospital Services	80% after Deductible	60% after Deductible
Outpatient Surgical Care	80% after Deductible	60% after Deductible
Outpatient Lab & X-ray	100% Deductible Waived	60% after Deductible
Emergency Room (Copay waived if admitted)	$500 Copay then 80% Deductible Waived	$500 Copay then 80% Deductible Waived
Ambulance	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	60% after Deductible
Rehabilitation Services	80% after Deductible	60% after Deductible
Mental Health/Substance Abuse Inpatient	80% after Deductible	60% after Deductible
Mental Health/Substance Abuse Outpatient	100% Deductible Waived	60% after Deductible
Mental Health/Substance Abuse Office Visit – PCP / Specialty	$30 Copay / $50 Copay	60% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***	**Retail**
Level One	$5 / $7.50 Copay	$5 Copay + 25%
Level Two	$30 / $45 Copay	$30 Copay + 25%
Level Three	$50 / $75 Copay	$50 Copay +25%
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	$0 Copay / Not Applicable	Not Applicable

BCBS Medical/Prescription Drug Plan

BlueCross BlueShield of Illinois – Blue Choice Options (BCO) HDHP **Group Number 309007**

Plan Features			
	In-Network - Tier 1 Blue Choice Options (BCO Network)	In-Network - Tier 2 Participating Provider Organization (PPO Network)	Out-of-Network
Calendar Year Deductible			
Individual	$4,750	6,000	7,500
Family	$4,750 x 2 = $9,500	$6,000 x 2 = $12,000	$7,500 x 2 = $15,000
Medical Out-of-Pocket (excludes Deductible)			
Individual	$0	$1,500	$2,500
Family	$0	$1,500 x 2 = $3,000	$2,500 x 2 = $5,000
Total Out-of-Pocket Maximum			
Individual	$4,750	$7,500	$10,000
Family	$4,750 x 2 = $9,500	$7,500 x 2 = $15,000	$10,000 x 2 = $20,000
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100%, Deductible Waived	100%, Deductible Waived	50% after Deductible
Office Visit	100% after Deductible	70% after Deductible	50% after Deductible
MARATHON PRIORITY CARE CLINIC OFFICE VISIT	**Preventive - $0 Diagnostic - $25**	**Preventive - $0 Diagnostic - $25**	**NA**
Inpatient Hospital Services	100% after Deductible	70% after Deductible	50% after Deductible
Outpatient Surgical Care	100% after Deductible	70% after Deductible	50% after Deductible
Outpatient Lab & X-ray	100% after Deductible	70% after Deductible	50% after Deductible
Emergency Room (Copay waived if admitted)	100% after Deductible	100% after Deductible	100% after Deductible
Ambulance	100% after Deductible	100% after Deductible	100% after Deductible
Durable Medical Equipment	100% after Deductible	70% after Deductible	50% after Deductible
Rehabilitation Services	100% after Deductible	70% after Deductible	50% after Deductible
Mental Health/Substance Abuse Inpatient	100% after Deductible	70% after Deductible	50% after Deductible
Mental Health/Substance Abuse Outpatient	100% after Deductible	70% after Deductible	50% after Deductible
Mental Health/Substance Abuse Office Visit	100% after Deductible	70% after Deductible	50% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***		
Level One	100% after Deductible	100% after Deductible	100% after Deductible
Level Two	100% after Deductible	100% after Deductible	100% after Deductible
Level Three	100% after Deductible	100% after Deductible	100% after Deductible
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	100% after Deductible	100% after Deductible	Not Covered

BCBS Medical/Prescription Drug Plan

BlueCross BlueShield of Illinois – Blue Choice Select (BCS) HDHP **Group Number OMB996**

Plan Features		
	In-Network Blue Choice Select (BCS Network)	**Out-of-Network**
Calendar Year Deductible		
Individual	$3,800	$7,500
Family	$3,800 x 2 = $7,600	$7,500 x 2 = $15,000
Medical Out-of-Pocket (excludes Deductible)		
Individual	$0	$2,500
Family	$0	$2,500 x 2 = $5,000
Total Out-of-Pocket Maximum		
Individual	$3,800	$10,000
Family	$7,600	$20,000
Preventive Care – Immunizations, Pap Smear, Mammogram, Prostate Exam, Routine Physical Exam	100% Deductible Waived	70% after Deductible
Office Visit	100% after Deductible	70% after Deductible
MARATHON PRIORITY CARE CLINIC OFFICE VISIT	**Preventive - $0 Diagnostic - $25**	**NA**
Inpatient Hospital Services	100% after Deductible	70% after Deductible
Outpatient Surgical Care	100% after Deductible	70% after Deductible
Outpatient Lab & X-ray	100% after Deductible	70% after Deductible
Emergency Room (Copay waived if admitted)	100% after Deductible	100% after Deductible
Ambulance	100% after Deductible	100% after Deductible
Durable Medical Equipment	100% after Deductible	70% after Deductible
Rehabilitation Services	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Inpatient	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Outpatient	100% after Deductible	70% after Deductible
Mental Health/Substance Abuse Office Visit	100% after Deductible	70% after Deductible
Prescription Drug Coverage	**Retail / Mail Order***	**Retail**
Level One	100% after Deductible	70% after Deductible
Level Two	100% after Deductible	70% after Deductible
Level Three	100% after Deductible	70% after Deductible
OTC Program (Select Antihistamines and Proton Pump Inhibitors)	Not Covered	Not Covered

Near Site Clinic for Medical Participants: Priority Care

Marathon Health

Primary & mental healthcare at little to no cost

with Marathon Health



As part of your benefits through Naperville 203, you and your eligible family members now have access to Marathon Health.

Primary care

- Little to no cost
- Same- and next-day visits for immediate needs
- 24/7 virtual access to manage your care
- Little to no wait
- More time with your provider

Services

- Annual physical exams
- Condition management
- Labs and onsite testing
- Medication management
- School and sports physicals
- Sick and immediate care

Mental health

- Little to no cost
- Licensed mental health provider
- Increased availability and access
- Care for ages 12 and up
- Your mental health provider collaborates with your Marathon Health providers

Services

- Anxiety, excessive worries
- Depressed mood, sadness
- Grief
- Irritability
- Stress
- Trauma
- Relationship concerns
- Substance or alcohol misuse

Priority Care - powered by Marathon Health
1160 E Ogden Ave
Naperville, IL 60563
Schedule your appointment
331-226-0315 | my.marathon.health

Naperville 203
Community Unit School District

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Near Site Clinic for Medical Participants: Priority Care

Marathon Health™



Get started

With Marathon Health

The Marathon Health patient portal and mobile app are quick and easy ways to manage your healthcare needs. This guide walks you through the process of creating your account and exploring all features.

STEP 1

Activate your patient portal

- Scan the QR code or visit **my.marathon.health**
- Click "Register My Account"

Enter the following information to create your secure online account

- First and last name
- Email address
- Social Security Number (Not required but will improve the account creation process.)
- Date of birth
- Home address and phone number
- Marathon Health access type

Once submitted, records will be reviewed to confirm eligibility, and you'll receive a follow-up email within 2-3 business days to complete your registration. After registering, proceed to step 2 to download the mobile app.

STEP 2

Download the mobile app

Scan the QR code or follow these steps to download from Apple App Store or Google Play Store

- Search for "Marathon Health" in the search bar
- Locate the Marathon Health app and tap on it
- Press the "Download"or "Install" button to begin installing the app
- Once the app is successfully downloaded and installed, you'll find the icon on your home screen

Note: Marathon Health must verify with your employer/union that you are eligible for this benefit Marathon Health is required by law to maintain the privacy and security of your protected health information under the Health Insurance Portability and Accountability Act We will not share any personally identifiable information with your employer.

Key features

- **Appointment scheduling:** Book appointments with your provider
- **Video visits:** Meet virtually with your care team
- **Messaging:** Communicate securely with your care team
- **Medications:** Manage your prescriptions and request refills
- **Health records:** Easily access your medical records
- **Incentives:** Earn rewards by prioritizing your health

Questions? Call 331-226-0315

Access is limited to eligible individuals and their family members who have partnered with Marathon Health through an employer, union group, or on their own.

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Near Site Clinic for Medical Participants: Priority Care

Marathon Health

How to Schedule an Appointment

1. Visit the Marathon Health portal at **my.marathon.health** (if you have not downloaded the app, its available on iOS and Android) and sign in.
2. Click on **Schedule an appointment.**
3. **Select the reason for your visit.** Use the quick access buttons to select a common visit reason or utilize the type ahead search bar to find a visit reason by symptom, condition, or illness. You can also click the link to view the complete list of visit reasons.
4. Select your visit type and click **Search Availability**. If you select **Virtual Visit** you will be prompted to select the state that you will be in at the time of your visit.
5. Use the filters to narrow your search by specific providers, health center, location, and more.
6. You can select a **specific provider** from the Provider drop-down menu, select a **specific date** on the calendar, or **click the arrows to see availability** for weeks at a time.
7. Click **Search Next Available Day** and select the day and time of your appointment.
8. Review your contact and insurance information as well as appointment details. Click **Confirm and Schedule Appointment.**

   Marathon Health will send you a reminder email and text message with appointment details 7 days in advance of the appointment, or immediately if the appointment is within 7 days.

   For video visits: Please enter a valid email address. You will receive an email or text message after you've scheduled and prior to your appointment with instructions on how to begin your video visit.

   For telephonic visits: Please enter a valid phone number. Your provider will call the phone number(s) listed at the time of your appointment.
9. **Your appointment is now scheduled!** Marathon Health will send you a confirmation email with your appointment details.

Guardian Dental Plan – Group Number 068729

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

Guardian's PPO Plan has access to one of the largest networks of dentists with two reimbursement levels that give you more control over savings. You will always save money with any dentist in Guardian's network and when the dentist belongs to a Tier 1 reimbursement level you will maximize your savings. Reimbursement for covered services received from a non-contracted dentist will be based on a percentile of the prevailing fee data for the dentist's zip code. To find a dentist in Guardian's PPO Network (DentalGuard Preferred), log on to www.Guardianlife.com or call 1.888.600.1600.

The information below highlights some of the plan features for covered services. Please contact Guardian for the benefit plan certificate for full coverage information.

Plan Features – Group # 068729	Tier 1	Tier 2
Calendar Year Deductible	$50 per Member	$50 per Member
Annual Maximum	$2,500 per Member (applies to all levels)	
Preventive Services	80% after deductible	80% of 90th UCR* after deductible
Basic Services	80% after deductible	80% of 90th UCR* after deductible
Major Services	50% after deductible	50% of 90th UCR* after deductible
Orthodontic Services (children under age 19)	50% after deductible	50% of 90th UCR* after deductible
Orthodontia Lifetime Maximum	$2,000 per Member (applies to all levels)	

Preventive Services include oral examinations (two per calendar year), x-rays, cleanings (two per calendar year), topical fluoride treatment (one per benefit year for children under age 19), and sealants.

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

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

***Please note:** Out-of-Network providers are paid based on the 90th UCR (Usual, Customary, and Reasonable). This means that 90% of providers in your area charge that amount or less for a given procedure. This is the amount that the insurance company will pay from an out of network provider. This results in lower out of pocket fees for the member. Please contact Guardian for more information.*



Guardian Vision Plan – Group Number 068729

When you enroll in one of Naperville Community Unit School District 203's medical/prescription plans, you are given the **option** to enroll in a vision care plan through Guardian. Vision health impacts your overall health. Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis. It is recommended that you have an eye exam once every 12 months.



To find an in-network vision provider (Davis Vision), visit www.guardianlife.com or call 1.888.600.1600.

The information below highlights some of your plan features. Please contact Guardian for the benefit plan certificate for full coverage information.

Plan Features – Group #68729	Participating Provider	Non-Participating Provider
Eye Examinations (1x every Calendar Year)	$10 Copay	$50 allowance
Lenses (1x every Calendar Year)		
Single	$10 Copay	$48 allowance
Bifocal	$10 Copay	$67 allowance
Trifocal	$10 Copay	$86 allowance
Contact Lenses (1x every Calendar Year)		
Elective (conventional and disposable)	$150 allowance, + 15% discount	$105 allowance
Medically Necessary	100%	$210 allowance
Frames (1x every 2 Calendar Years)	$150 allowance, + 20% discount	$48 allowance

Members will receive significant lens option discounts which will range from 20-60% off the Usual & Customary charge. For example, standard progressive lenses will cost $50 and scratch resistant coating will cost $20. Oversized lenses and fashion or gradient tinting of plastic lenses are covered in full.

Second pair of glasses is 50% off at Visionworks, and 30% off at other in network eye care professionals.

Savings of 40-50% off the national average price of traditional Lasik is available at over 1,000 locations across the Davis nationwide network of laser vision correction providers.

Payroll Contributions

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

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

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

	EMPLOYEE ONLY*			FAMILY*		
	Full-rate Monthly Premium	**26-pay Employee Contribution**	**20-pay Employee Contribution**	**Full-rate Monthly Premium**	**26-pay Employee Contribution**	**20-pay Employee Contribution**
Medical/Prescription Blue Choice Options PPO	$974.53	$67.47	$87.71	$2,924.53	$202.47	$263.21
Medical/Prescription Blue Choice Select PPO	$738.28	$51.12	$66.45	$2,208.53	$152.90	$198.77
Medical/Prescription Blue Choice Options HDHP	$718.58	$49.75	$64.67	$2,149.58	$148.82	$193.46
Medical/Prescription Blue Choice Select HDHP	$594.12	$41.13	$53.47	$1,777.30	$123.04	$159.96
Dental	$44.47	$3.08	$4.00	$108.26	$7.50	$9.75
Vision	$5.31	$0.37	$0.48	$13.35	$0.92	$1.20

Contribution amounts listed above assume the following:

- ✓ **Full-time Status:** Employee contribution amounts are increased for employees who do not work full time. These employees should refer to their union contracts or contact the Employee Benefits Specialist for specific contribution amounts
- ✓ **Wellness Program Participation:** Employees and spouses must show proof of an annual physical obtained at Marathon Health Clinic or with your PCP. If you fail to provide proof an additional $300 surcharge will be applied to your premiums annually for each person that does not comply. Employee contributions will be adjusted accordingly on the first payroll in January.
- ✓ **Spousal/Civil Union Partner Surcharge Exemption:** If you enroll your spouse or civil union partner in a District 203 medical plan **and** they have access to medical coverage through their own employer that meets Affordable Care Act (ACA) essential benefits, minimum value, and affordability requirements, a spousal surcharge will apply. You will be assessed a surcharge of $3,600 annually ($138.46 per payroll based on 26 pays and $180 per payroll based on 20 pays) for the BCO plans. You will be assessed a surcharge of $2,600 annually ($100 per payroll based on 26 pays and $130 per payroll based on 20 pays) if you elect a select (BCS) plan. In addition, if you enroll your spouse and have a household income of $402,000 or more, regardless of group coverage, there will be an additional $7,200 annually. If both spouses work in the district, the additional surcharge will not apply. The surcharge applies regardless if the District 203 coverage is primary or secondary but does not apply to spouses/civil union partners with non-company sponsored health plans such as COBRA, Medicare and Veteran's Affairs.

Wellness Program – Powered by Marathon

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

Updated Wellness Program

D203 now offers two options for completing your wellness check to earn the 2028 Wellness Premium Rate.

As a valued Naperville employee and Marathon Heath patient, your health and well-being are our top priority. We are proud to support you every step of the way on your journey toward better health.

Employees and spouses covered under the District health plan can participate in our Wellness Incentive Program to qualify for the Wellness Premium Rate. This rate provides a $300 savings for the 2028 plan year. Each participant, employee and spouse, can earn their own $300 premium savings.

How to Earn Your Incentive:

Complete your Wellness Check any time between November 1, 2026-October 31, 2027.

Option 1: Complete a biometric screening at your Marathon Clinic.

**If you go to the clinic, Marathon will submit the necessary paperwork to receive the incentive.*

Option 2: Complete an Annual Exam with Preventive Labs with an outside provider.

**If you have your annual physical with preventive labs with your outside primary care physician, download the required form and upload it in the Marathon Portal by October 31st, 2027. Be sure to visit BCBSIL.com to find in network providers.*

To schedule an appointment at your Marathon Clinic, call 331-226-0315 or visit my.marathon.health.



Teladoc – General Medical

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



When can I use Teladoc?

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

What conditions can the doctor evaluate?

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

Who are the doctors at Teladoc?

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

What does it cost for a consult with Teladoc?

- Blue Choice Options PPO and Blue Choice Select PPO members pay $5.00 per consult
- Blue Choice Options HDHP and Blue Choice Select HDHP members pay $55.00 per consult

Teladoc – Behavioral Health

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

Benefits of using the Behavioral Health option through Teladoc

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

Cost for Blue Choice Options PPO and Blue Choice Select PPO Plans

$30 Copay for the first Behavioral Health Consultation with a psychiatrist
$30 Copay for all subsequent Behavioral Health Consultations with a psychiatrist
$30 Copay for each Behavioral Health Consultation with a therapist other than a psychiatrist

Cost for Blue Choice Options HDHP and Blue Choice Select HDHP Plans

$235 for the first Behavioral Health Consultation with a psychiatrist
$105 for all subsequent Behavioral Health Consultations with a psychiatrist
$95 for each Behavioral Health Consultation with a therapist other than a psychiatrist



Teladoc – Nutrition & Dermatology

Naperville Community Unit School District 203 offers Nutrition and Dermatology options in conjunction with current Teladoc services. Teladoc nutrition providers are registered dieticians and supports a wide range of specialty conditions such as diabetes, sports nutrition, gastrointestinal disorders and prenatal care. Teladoc dermatology providers are licensed dermatologists that can provide services on a wide variety of skin issues. Initiate services online at Teladoc.com or via the mobile app.

Benefits of using the Nutrition option through Teladoc

Can be used from the comfort of your own home, when you are traveling, or if you have a student away at school. It can be accessed from anywhere at anytime.
Members can receive a personalized nutrition guide with custom meal plan, shopping guide, and more.
Nutrition integrates with other Teladoc Health clinical services for easy access to comprehensive care.

Benefits of using the Dermatology option through Teladoc

Can be used from the comfort of your own home, when you are traveling, or if you have a student away at school. It can be accessed from anywhere at anytime.
A dermatologist will review images, make a diagnosis and provide a personalized treatment plan right in the app.
Interact with the same dermatologist for the next 7 days for follow-up needs after initial appointment.
Treats acute or ongoing skin issues like psoriasis, skin infection, rosacea and more.
Providers can prescribe approved medications.

Cost for Blue Choice Options PPO and Blue Choice Select PPO Plans

$30 Copay for Nutrition consults
$30 Copay for Dermatology consults

Cost for Blue Choice Options HDHP and Blue Choice Select HDHP Plans

$61 for Nutrition consults
$89 for Dermatology consults





Teladoc – Livongo (Chronic Care Management Plus)

Healthcare is going digital and with Livongo, you have the means to live healthier. The Livongo program, also known **as Chronic Care Management Plus (CCM+)** aims to help members struggling with diabetes, hypertension, and/or prevention.

The best part? It's **no cost** to you! This program is covered in full through the District as we continue to strive to offer our members benefits that make a difference.

Livongo **(CCM+)** offers the following:

- Diabetes – provides a high-tech meter, unlimited strips and lancets, and expert assistance
- Hypertension – provides a connected monitor and one-on-one coaching
- Healthy Living and Diabetes Prevention – provides a connected scale and expert guidance
- Health experts, personalized plans and more!

Visit TeladocHealth.com/Go or call 800-835-2362



Hinge Health

Hinge Health

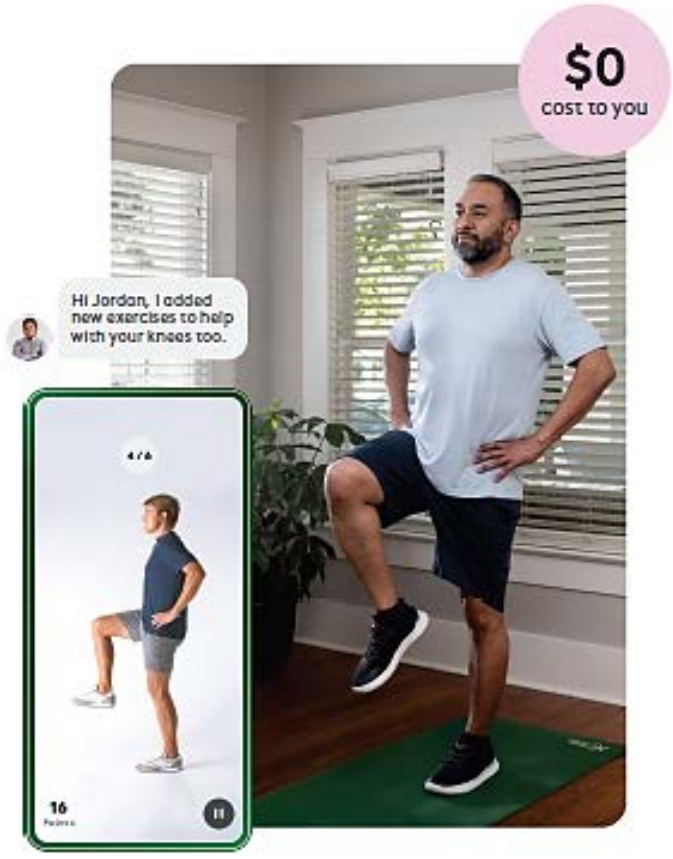
Your partner for pain relief

With Hinge Health, you can get virtual exercise therapy and more from real people who are dedicated to helping you feel your best.

Specialized care, personalized for you

Reduce everyday joint and muscle aches. Recover from an injury. Improve your mobility.

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals



How do I get started?

Hinge Health will reach out to eligible members with program details and next steps.

Eligibility: Participants must be clinically eligible, 18+ and enrolled in a Fully Insured medical plan through BCBSIL.

Hinge Health is an independent company that has contracted with Blue Cross and Blue Shield of Illinois to provide an online musculoskeletal program for members with coverage through BCBSIL. BCBSIL make no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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

Inspira Flexible Spending Accounts (FSA)

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

Health Care Flexible Spending Account (HFSA)

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

- You may contribute up to $3,400 to your HFSA for the 2027 Plan Year. This contribution limit is subject to change per IRS regulations.
- Your share of expenses which are not reimbursed by a health care plan, such as copays, deductibles, and out-of-pocket expenses, are eligible to be claimed from the HFSA plan.
- The IRS and Naperville Community Unit School District 203 allow you to claim any unused HFSA amounts after the end of the plan year for expenses incurred until March 15 of the new plan year. All claims, including those incurred during the grace period, must be submitted by March 31. The “Use It or Lose It” rule applies to any funds left in your HFSA account after the grace period has expired.

Dependent Care Flexible Spending Account (DCA)

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

- You may contribute up to $7,500 to your DCA for the 2027 Plan Year if you are single or if you are married and file a joint return.
- You may contribute up to $3,750 to your DCA for the 2027 Plan year if you are married and file separate income tax returns.
- Expenses such as day care, before- and after-school programs, summer day camp and adult day care are eligible to be claimed from the DCA plan.

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



Lively Health Savings Account (HSA)

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

To be eligible to open or contribute to an HSA, you must be:
- ✓ Covered by a qualified HDHP
- ✓ Not enrolled in Medicare
- ✓ Not listed as a dependent on another person's income tax return
- ✓ Not covered by another non-HSA qualified medical plan – including an HFSA

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

***Note for Annual Benefits Enrollment*:** If you switch to one of the HDHPs from a PPO and have a health care flexible spending account, the balance in your HFSA account must be zero ($0.00) on December 31, 2026. If you carry any balance into the following year, you cannot become HSA-eligible until the first day of the month after the grace period ends – April 1, 2027. Your 2027 total HSA contribution cannot exceed the maximum based on a nine-month year. The employer contribution to your Health Savings Account will be prorated accordingly, as well as your employee contribution, as applicable. If you have funds in your HFSA, you may continue to claim expenses against your HFSA through the grace period.

Contributions to an HSA may be made by an employee using pre-tax payroll deductions, bank deposits, or a one-time rollover from an IRA, as well as those made by District 203. HSA contributions are limited by the U.S. Internal Revenue Service based on the calendar year. The maximum amount that can be contributed to an HSA for 2027 (employee and employer contributions combined) is $4,500 for employee only coverage and $9,000 for family coverage. Individuals over age 55 may make an additional "catch-up" contribution of $1,000 annually.

District 203 has committed to contributing to the Lively HSA of each eligible employee who participates in the Blue Choice Options HDHP or Blue Choice Select HDHP for the 2027 Plan Year. District 203 will contribute $1,500 for employee only coverage and $3,000 for family coverage to employees who remain in or elect a high-deductible health plan during Annual Benefits Enrollment. The annual district contribution will be deposited in **January 2027** as long as the employee has an active Lively HSA through Naperville 203. For the balance of the year, contributions will be prorated for employees not eligible for an HSA for the entire year.

To maximize the tax advantages of your contributions, we highly encourage you to contribute through payroll deductions. This method ensures your contributions are made on a pre-tax basis, which can reduce your taxable income. If you choose to contribute to your plan outside of payroll, please let your Naperville Benefits team know, and we can provide you with instructions on adjusting your payroll contributions if needed. Please remember that contributions made outside of the benefits/payroll system will not have the same pre-tax advantages.

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

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

Guardian Life and AD&D Plan
Group # 068729

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

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

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

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

** Minimum life benefit; the amount of benefit will be reduced to 65% at age 70 and will be further reduced to 50% at age 75*

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



Guardian Long-Term Disability Plan
Group # 068729

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

The information below highlights some of the plan benefits. Please contact Guardian for the benefit plan certificate for full coverage information.

- Benefits begin after 60 consecutive days of disability or the day allotted/accrued sick time is exhausted, whichever is greater
- Pays 60% of basic monthly income up to a maximum of $10,000 per month
- Benefits continue until you reach your normal retirement age under Social Security, as long as you continue to be disabled
- Benefits may be available if working on a part-time basis while disabled
- Survivor benefit is equal to three times the insured's last monthly benefit if death occurs after 180 consecutive days of total disability

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



Guardian Voluntary Life Insurance Plan
Group # 068729

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

Insured	Benefit	Guaranteed Issue Amount
New Employee	Option of $10,000 to $500,000 in increments of $10,000	All Ages: $250,000
Current Employee	Option of $10,000 to $500,000 in increments of $10,000	Current elected amount, plus an additional $50,000 up to $250,000
Spouse/Civil Union Partner	Option of $10,000 to $500,000 in increments of $10,000 (cannot exceed 100% of employee amount)	All Ages: $50,000
Dependent Children	14 days to 6 months: $1,000 6 months to Age 26: Choice of $5,000, $10,000, $15,000, or $20,000	$20,000

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

All employee and spouse/civil union partner premium rates are age-banded and based on the age at last birthday.

During open enrollment for 2027, employees that are currently enrolled in voluntary life/ADD coverage, may increase current amount up to an additional $50,000, not to exceed the guarantee issue amount without submitting evidence of insurability.

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

Age	Rate for All Members
Under 30	$0.60
30 - 34	$0.80
35 - 39	$0.90
40 - 44	$1.47
45 - 49	$2.56
50 - 54	$4.47
55 - 59	$7.95
60 - 64	$9.69
65 - 69	$14.37
70+	$26.53

Guardian Voluntary Life Insurance Plan
Group # 068729

Eligible children are unmarried, financially dependent natural, adopted, foster or stepchildren in the custody of an eligible employee. One rate applies for all eligible dependent children in the family, regardless of number. Coverage for dependent children terminates at age 26 but is extended up to age 30 if dependent child is an Illinois resident honorably discharged from the armed forces. Children beyond age 26 will continue to be covered if they are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and are chiefly dependent on the eligible employee for support and maintenance. **You may elect child voluntary life coverage, even if the employee or spouse are not electing voluntary life coverage.**

Dependent Children Rate per Month

	Option 1	Option 2	Option 3	Option 4
Coverage amount from age 14 days to 6 months	$1,000	$1,000	$1,000	$1,000
Coverage amount from age 6 months to 26 years	$5,000	$10,000	$15,000	$20,000
Rate	$0.82	$1.64	$2.46	$3.28

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

Age	Amount of Coverage Reduces to:
75 - 79	60.0% of the amount in force at age 74
80 - 84	35.0% of the amount in force at age 74
85 - 89	28.0% of the amount in force at age 74
90 and over	20.0% of the amount in force at age 74

Guaranteed Issue: Benefit issue amounts are guaranteed to a certain level without regard to health status if enrollment occurs within 31 days of your effective date. The guaranteed issue amount is up to $250,000 for new employees under age 60. Spouses/civil union partners under age 60 are guaranteed an issue of up to $50,000 and dependent children are guaranteed an issue of up to $20,000. At annual enrollment employees may increase their current amounts by up to $50,000 without submitting an Evidence of Insurability (EOI) as long as the elected amount remains under the guaranteed issue amount of $250,000. If you apply for benefits above the guaranteed issue amounts, you may be subjected to evidence of insurability and a health screening prior to coverage approval.

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

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

Guardian Voluntary Critical Illness Plan
Group # 068729

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

Insured	Benefit	Guaranteed Issue Amount
Employee	Option of $5,000 to $30,000 in increments of $5,000	$30,000
Spouse/Civil Union Partner	Option of $5,000 to $30,000 in increments of $5,000	$30.000
Dependent Children	25% of Employee's Benefit limited to $7,500 maximum	$7,500

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

Employee and Spouse/Civil Union Partner Rate per Person per Month based on the below Age-Bands (child rate is included in employee amount)

Benefit Amount	Less than 30	30-39	40-49	50-59	60-69	70+
$5,000	$1.55	$3.15	$4.40	$7.40	$12.25	$20.65
$10,000	$3.10	$6.30	$8.80	$14.80	$24.50	$41.30
$15,000	$4.65	$9.45	$13.20	$22.20	$36.75	$61.95
$20,000	$6.20	$12.60	$17.60	$29.60	$49.00	$82.60
$25,000	$7.75	$15.75	$22.00	$37.00	$61.25	$103.25
$30,000	$9.30	$18.90	$26.40	$44.40	$73.50	$123.90

All employee and spouse/civil union partner premium rates are age-banded and based on the age at last birthday.

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

Guardian Voluntary Critical Illness Plan
Group # 068729

Covered Critical Illnesses fall into one of four categories:

- **Cancer Related:** Invasive Cancer, Carcinoma in situ
- **Cardiovascular Related:** Heart Attack, Stroke, Coronary Artery Bypass
- **Pregnancy and Childbirth Related:** Infertility non-surgical, infertility surgical
- **Other:** Kidney (Renal) Failure, Major Organ Failure

Plan Features	Benefit
Diagnosis of Heart Attack, Invasive Cancer, Severe Stroke, Major Organ Failure or Kidney (Renal) Failure	100% of amount in force
Diagnosis of Coronary Artery Bypass, Moderate Stroke	50% of amount in force
Recurrence (Same Category) – Same Illness must be separated by 6 Months, Different illness in same category has no time requirement	Varies based on Category (50%-0%)
Infertility non-surgical: Prescription oral medication, prescription injectable medication, intrauterine insemination (IUI) Infertility surgical: Removal of uterine fibroids, polyps, uterine septum, endometriosis tissue or fallopian tube scare tissue, varicocelectomy, egg removal for the purpose of artificial insemination for the purpose of in vitro fertilization, other surgical intervention performed to treat infertility	Infertility non-surgical: 1 time, lifetime benefit of 10% of the elected amount Infertility surgical: 1 time, lifetime benefit of 30% of the elected amount
Subsequent Occurrence (Differed Category) diagnosis must be separated by at least 6 months	100% of Basic or Partial Benefit
Lifetime Maximum Benefit per Category	2 occurrences per category when applicable
Completion of Wellness / Health Screening	$50 per 12-month period

Guaranteed Issue: Benefit issue amounts are guaranteed to a certain level without regard to health status if enrollment occurs during the Annual Benefits Enrollment period or within 31 days of first becoming eligible. The guaranteed issue amount is up to $30,000 for employees and spouses/civil union partners and $7,500 for dependent children.

Pre-Existing Conditions: Diagnosis must be made while covered under the plan in order for the benefit to pa out.

Waiting Period: There is no waiting period for benefits to be paid out.

Portability: After coverage has been in effect for at least 1 day, coverage can continue if the insured is under the age of 70 and no longer meets the employment eligibility requirements for reasons other than retirement or overall termination of the group policy. Premiums charged will be based on the prevailing rate charged to all insured who continue coverage under this provision and will be billed directly to the insured.

Voluntary Accident Plan
Group # 068729

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

	Value Plan	Advantage Plan	Premier Plan
Wellness Screening	$50	$75	$100
Ambulance	$150	$200	$300
Emergency Room Treatment	$150	$200	$250
Diagnostic Examination	$100 per CT/MRI Scan	$200 per CT/MRI Scan	$400 per CT/MRI Scan
Hospital Admission	$500	$1,000	$1,500
ICU Hospital Admission	$1,000	$2,000	$3,000
Hospital Confinement	$200/day 365-day max	$250/day 365-day max	$350/day 365-day max
ICU Confinement	$400/day 15-day max	$500/day 15-day max	$700/day 15-day max
Fractures	Up to $5,000	Up to $8,000	Up to $10,000
Dislocations	Up to 4,000	Up to $5,000	Up to $7,000
Transfusion	$300	$300	$300
Burns	9-18 square inches = $0 - $2,000 18-35 square inches = $1,000 - $4,000 Over 35 square inches = $3,000 - $12,000		
Concussion	$100	$200	$300
Exploratory Surgery	$300	$400	$500
Knee Cartilage Surgery	$250	$500	$750
Abdominal/Thoracic Surgery	Up to $1,000	Up to $1,500	Up to $2,000
Ruptured Disc Surgery	$250	$500	$750
Physical Therapy	$25/day up to 10 days	$35/day up to 10 days	$50/day up to 10 days
Accidental Death - Employee	$25,000	$50,000	$100,000
Accidental Death - Spouse	$12,500	$25,000	$50,000
Accidental Death - Children	$5,000	$10,000	$20,000
Dismemberment - One member	50% of Death Benefit	50% of Death Benefit	50% of Death Benefit
Dismemberment - Two or more members	100% of Death Benefit	100% of Death Benefit	100% of Death Benefit

Voluntary Accident Plan
Group # 068729

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

Monthly Rates

	Value Plan	Advantage Plan	Premier Plan
Employee Only	$6.14	$9.17	$13.01
Employee and Spouse/Civil Union Partner	$9.79	$14.58	$20.57
Employee and Child(ren)	$10.28	$15.12	$20.91
Family	$13.93	$20.53	$28.47

Accidental Death & Dismemberment: There are no age reductions to the Accidental Death & Dismemberment benefits.

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

Portability: After coverage has been in effect for at least 1 day, coverage can continue if the insured no longer meets the employment eligibility requirements for reasons other than retirement or overall termination of the group policy. Premiums charged will be based on the prevailing rate charged to all insured who continue coverage under this provision and will be billed directly to the insured.

Retirement Savings Plan

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

A 403(b)/457 plan allows you to contribute a portion of your compensation on a **pre-tax** basis in order to save for your retirement. The pre-tax contributions are made to the plan by payroll deduction and grow tax-free until they are withdrawn. This means you are lowering your taxable income now and will potentially lower the amount of income tax you will pay on your retirement funds at the time of withdrawal, as you may be in a lower tax bracket then. The District 403(b) plan also allows you to contribute a portion of your compensation on a **post-tax** (Roth) basis. These contributions are also made to the plan by payroll deduction.

All employees are eligible to make contributions to these plans.

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

In 2026, you may contribute up to $24,500 to both your 403(b) plan and your 457(b) plan. The Limit for 2027 has not been set yet by the IRS. You may be eligible for additional 403(b) contributions if you will be age 50 or older in the 2027 calendar year or if you have completed at least 15 years of employment with Naperville 203 in 2026. Please reach out to US OMNI to see if you qualify for the additional contribution options. The contribution limits are subject to change per IRS regulations.

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



Employee Assistance Program (EAP)

Everyone needs a little help now and then dealing with stress, work or family issues, or personal concerns. Naperville Community Unit School District 203's Employee Assistance Program (EAP) provides confidential services through a network of licensed counselors and professionals to help you get your life back in balance. The EAP is offered at no cost and is available to all employees and their families. To access the EAP, please call 855.239.0743 or visit guidanceresources.com

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

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

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



Healthcare Terms

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

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

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

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

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

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

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

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

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

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

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

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

Appendix A

Semi-Annual Notice Regarding Health Insurance Coverage for Dependents

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

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

Military Veterans: In connection with military veteran dependents 26 years of age and older, such dependents must:

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

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

Notice of Employer Contributions to HSAs

Naperville Community Unit School District 203 provides contributions to the Health Savings Account (HSA) of each eligible employee who is enrolled in the District's Blue Choice Options HDHP or Blue Choice Select HDHP. For 2027, the District will load the entire annual contribution from the District on the first payroll in January 2027. If you are an eligible employee, you must do the following in order to receive an employer contribution:

1. Establish a Lively HSA account on or before the last day in February of 2027 and;
2. Notify your Employee Benefits Specialist of your HSA account information (Lively account number) on or before the last day in February of 2027 in writing or by email.

If you establish your HSA on or before the last day of February in 2027 and notify District 203 of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for 2026 by April 15, 2027. If, however, you do not establish your HSA or you do not notify the district of your HSA account information by the deadline, this district is not required to contribute to your HSA for 2027.

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

Appendix A

Important Notice Regarding Medicare

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

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

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back. *Please contact BCBSIL for more information about what happens to your coverage if you enroll in a Medicare Part D prescription drug plan.*

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

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact Member Advocacy for further information. **This is a yearly notice**. You will also get it before the next period you can join a Medicare drug plan and if your current drug coverage changes. You also may request a copy of this notice at any time.

Appendix A

Important Notice Regarding Medicare

For More Information about Your Options under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage

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

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

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

Appendix A

Federal Notices

Newborns' and Mothers' Health Protection Act

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

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

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

Women's Health and Cancer Rights Act

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

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

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

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

Notice Regarding Outcomes Based Wellness Program

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

However, employees and spouses on the Naperville District 203 BlueCross BlueShield health plan who choose to participate in the biometric screening will be eligible to receive the with-Wellness premium for the 2027 plan year. Although you are not required to complete the Health Risk Assessment, participate in the biometric screening and achieve certain health-related outcomes, only employees and spouses who do so will be eligible to receive the with-Wellness premium for the 2027 Plan Year.

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Naperville District 203 may use aggregate information it collects to design a program based on identified health risks in the workplace, Your information will never be disclosed publicly or to the employer unless expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

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

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

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

Appendix A

Privacy Practices Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to Naperville Community Unit School District 203.

Summary of Our Privacy Practices

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

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

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

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

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

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

Contact Information

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

Our Legal Duty

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

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

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

Uses and Disclosures of Your Medical Information

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

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Privacy Practices Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights

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

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

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

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

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

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

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Privacy Practices Notice

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

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

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

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

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

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

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

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

Complaints

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

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

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

Appendix B

BlueCross BlueShield of Illinois

Your life is busy. Blue Cross and Blue Shield of Illinois has you covered. BAM℠ gives you the tools you need to get the most from your medical and pharmacy benefits whenever and wherever you need them.

Your Access, Your Way

You choose how to access your benefits

Use BAM from your desktop, mobile device or download the free BCBSIL App from The App Store or Google Play. Whether you're at your desk or on the go, BAM is there for you with tools and features that give you the freedom to manage your health care anytime and anywhere.

Digital Member ID

- Share your digital ID card with your doctor's office or pharmacy.
- You can also view, download, print or order a new ID card.

Find Care

- Find nearby care providers and pharmacies whether you're at home or traveling.
- Schedule a virtual visit when you're traveling, need after-hours care or just want to skip the waiting room.

Secure Messaging

- Send messages* to our trained clinicians on your schedule.
- Message customer service with questions about your claims.

Check Your Virtual Medicine Cabinet

- Compare drug costs at different pharmacies.
- Get details about your prescriptions, including lower-cost options, pre-approvals and refills.

Use Account Settings to set Your Preferences

- Get your notifications by text, email or mail.
- Choose your language.
- Go paperless to get your explanation of benefits more quickly and securely.

Claims, Coverage and Wellness

- Review your benefit highlights, claims or download your EOB.
- Get clinical review status and details.
- Opt in to healthy programs, get preventive guidelines, wellness tips and other topics that you choose.

Register Now to Start Getting the Most from Your Benefits

Register online for BAM. Use the same login for the app. No matter how you choose to connect, BAM gives you 24/7 access to your benefits so you can live your life and manage your health your way. You can do it all. With your BAM.

Get Started

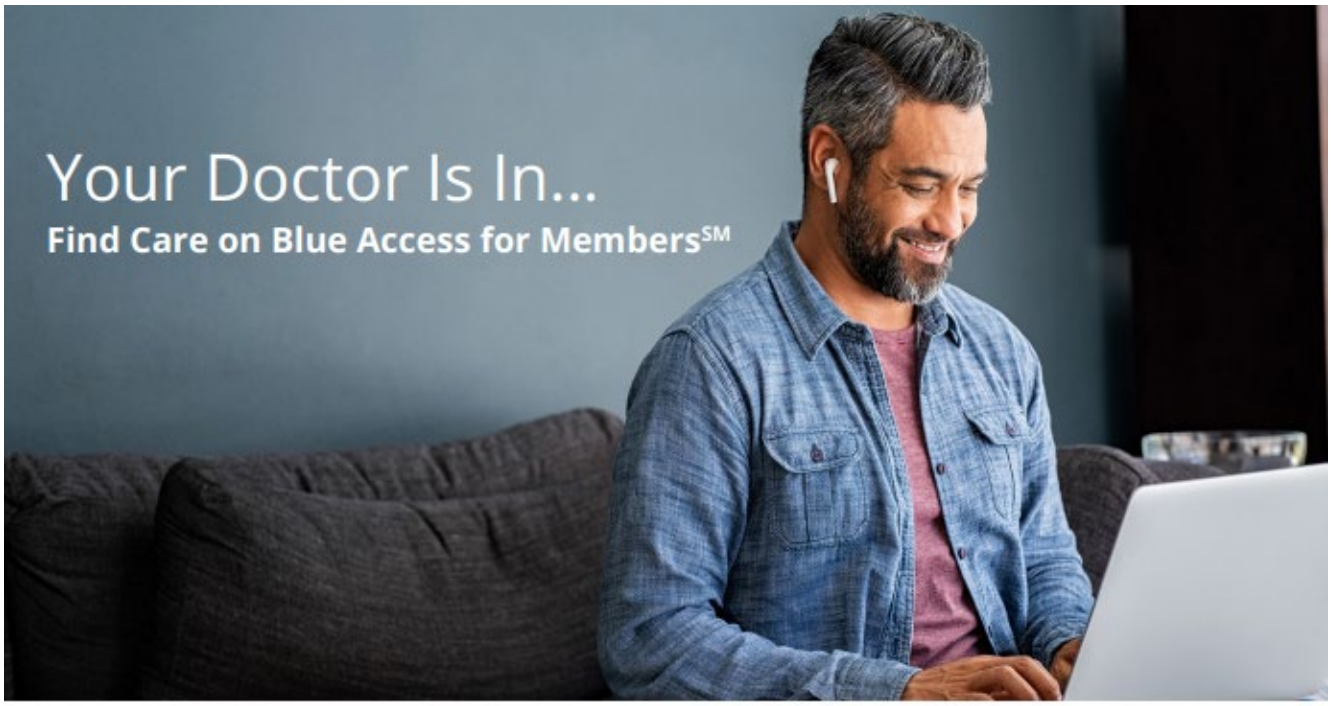
Online: Go to mybam.bcbsil.com to log in or create an account – **OR**

Get the App: Scan the QR code or text BCBSILAPP to 33633** for a download link.

* Clinicians and customer service respond during business hours. Please allow two business days for replies. You can send and read messages anytime.
** Message and data rates may apply. Terms and conditions and privacy policy are available at bcbsil.com/mobile/text-messaging.
This material is only for illustration purposes. Your group's coverage types and benefits may be different.

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Appendix B



It's easy to find a provider and manage your health care expenses.

Find Care on BAM℠

We make it easy to find in-network health care providers and manage your out-of-pocket costs.

Go to **bcbsil.com** to log in or create an account on BAM. Then, look for **Find Care** to:

- Find in-network providers, clinics, hospitals and pharmacies.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Compare quality, awards for doctors, hospitals and more.
- Read or add reviews for providers.
- Estimate the out-of-pocket costs for more than 1,700 health care procedures, treatments and tests.*
- Find cost savings opportunities for prescription drugs using the Medication Finder tool.*

* Not all plans provide this information.

Find a Doctor Wherever You Are

- **Log in to BAM.** Use your ZIP code to find providers in your network.
- **Search as a guest.** Go to bcbsil.com, choose Find Care and use the ZIP code at your location to find in-network providers near you.
- **Need more help?** Call 800-810-BLUE (2583) Also applies to Global® Core.



Stay Connected with BCBSIL

Even on the go you can manage your ID cards and stay on top of claims activity, coverage information and prescription refill reminders. It's easy: Log in or create a BAM account at **bcbsil.com**.

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Appendix B



Blue Choice Options℠

You know that you may save money when you see doctors and hospitals in your health plan's PPO network. But, did you know that with your Blue Choice Options benefit plan, you can save more money by using a doctor or hospital that is part of the Blue Choice OPT PPO℠ network?

What Is a Blue Choice Options Plan?

Learn about the different tiers so you can make smart choices and get the best value.

Why Using a Blue Choice OPT PPO Network Provider Saves You Money

The Blue Choice OPT PPO network has many doctors and hospitals that can meet all your health care needs. They all meet Blue Cross and Blue Shield of Illinois (BCBSIL) quality standards and have agreed to offer you care and services at a lower cost.

Tier 1
Blue Choice OPT PPO Network
Best value, the least out-of-pocket costs with in-network providers

Tier 2
Larger Statewide PPO Network
Larger network, more out-of-pocket costs with these providers

Tier 3
Out-of-Network
Out-of-network, highest out-of-pocket costs, you may have to pay those fees up front

Appendix B

How to Find a Tier 1 or Tier 2 Provider

Log in to Blue Access for Members℠ (BAM℠) at **bcbsil.com/member**, register for a BAM account using your name, date of birth and identification number found on your member ID card. When you search for providers in BAM, it will take you to network providers only.

For basic provider searches, you use Provider Finder® without logging in to BAM. Visit **bcbsil.com** and click on the **Find Care** tab and select **Find a Doctor or Hospital**, and click **Search as Guest**. Under **Plans**: enter your search criteria:

- When you choose **Blue Choice Options℠ (BCO)**, you will get a list of Tier 1 providers only.*
- When you choose **Participating Provider Organization (PPO)**, you willl get a list of Tier 2 BCO providers.
- Or you can Browse by Category or Search for Names and Specialties.

* If you change the option to view "All Tiers", then results are sorted with Tier 1 providers to the top and Tier 2 providers are displayed below. The top tier providers will have Tier 1 listed by their names and the Tier 2 providers will just have the provider's name with no tier listed.

Choosing Tier 1 and 2 Providers Can Help You Save Money

	Tier 1 Blue Choice OPT PPO Network	Tier 2 Larger Statewide PPO Network	Tier 3 Out-of-Network**
Doctor Visit	Cost is $200 You pay $15	Cost is $200 You pay $30	Cost is $200 You pay $200
Specialist Visit	Cost is $200 You pay $30	Cost is $200 You pay $50	Cost is $200 You pay $200
2-Day Hospital Stay	Cost is $5,000 You pay $1,400	Cost is $5,000 You pay $2,900	Cost is $5,000 You pay $5,000

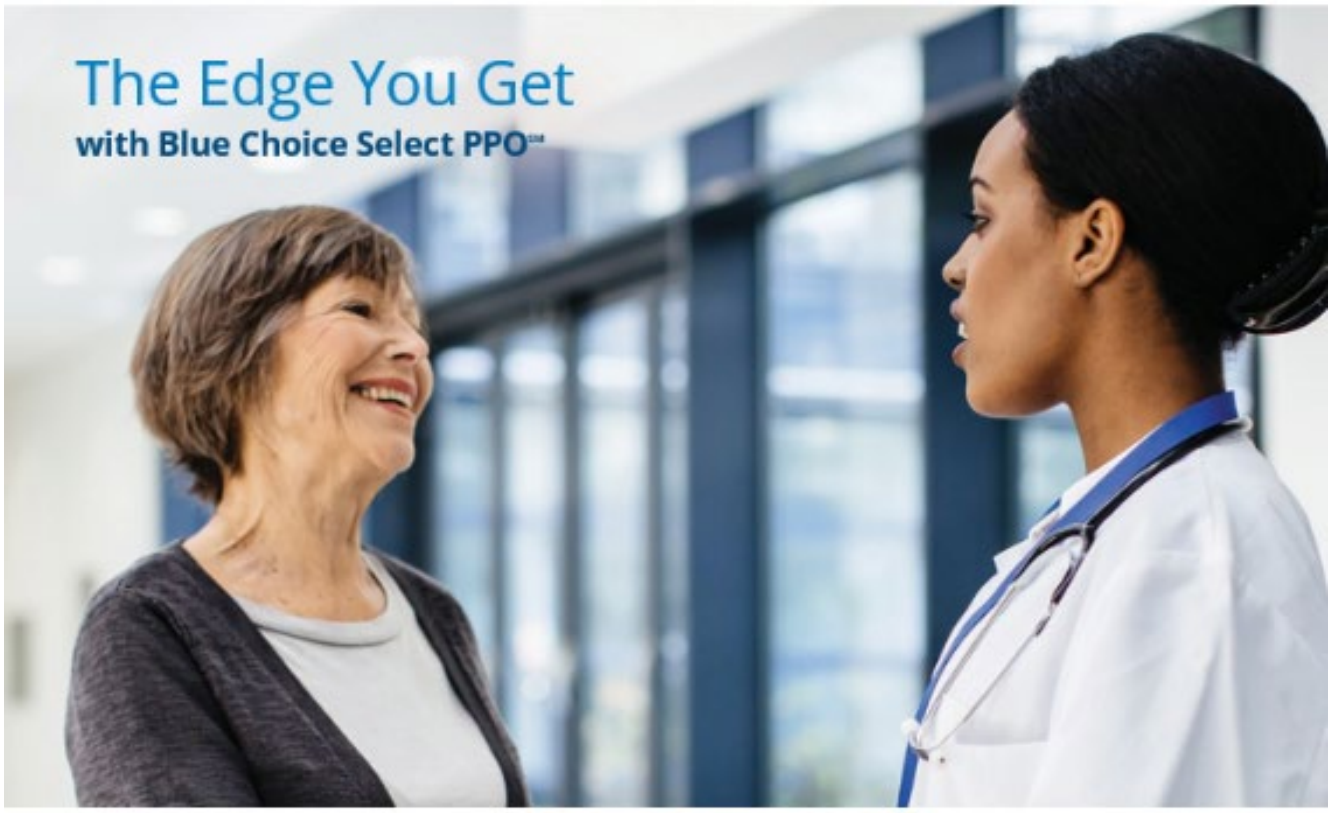
** Applied to member's deductible. Once deductible is met, pays at percentage designated by plan. Benefit information is based on a $1,000 deductible and 90% coinsurance for Tier 1, a $2,000 deductible and 70% coinsurance for Tier 2, and a $8,000 deductible and 50% coinsurance for OON. These examples are stand-alone and do not track the member's out-of-pocket max.



Need Help Finding a Network Provider?

Call the toll-free number on the back of your member ID card.

Appendix B



Giving you access to a network of quality physicians and hospitals at a lower cost.

The Blue Choice Select PPO plan offers access to select high quality, independently contracted hospitals and physicians nearly everywhere in Illinois.* To be a Blue Choice Select PPO member, you must live within the geographic area that the Blue Choice PPO℠ network serves (additional information is available in the Benefit Booklet).

The hospital network is based on location, the number of board-certified physicians on staff and other quality measures that Blue Cross and Blue Shield of Illinois (BCBSIL) sets for all its networks.

The Blue Choice Select PPO plan gives you the freedom to access care without having to obtain a referral to see a specialist.

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

When you use a Blue Choice PPO network provider, you will pay less out of pocket, you won't have to file any claims and you get the highest level of benefits. If you use a doctor or hospital in Illinois, but outside the network, you'll still be covered, but your out-of-pocket costs will be much higher.

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

Appendix B

Blue Choice Select PPO

What do you get with Blue Choice Select PPO?

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

Out-of-state coverage

You and your covered family members have access to health care benefits when out of state under the BlueCard® PPO Program. Blue Cross and Blue Shield (BCBS) Plans throughout the country have PPO networks of doctors, hospitals and other health care providers. Get information by calling the customer service number on the back of your member ID card, or the BlueCard Access number at **800-810-BLUE (2583)**. All you need to do is show your BCBSIL member ID card to the doctor's or hospital staff.

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

Get the support and tools needed to make health care decisions

- **Blue Access for Members℠ (BAM℠)** – a secure, online service where you can:
  - Access claim information, view Explanation of Benefits statements and confirm coverage
  - Search for a physician, hospital or other health care provider
  - Review a hospital's health outcomes data, based on specific diagnoses and procedures
- BCBSIL's customer service team can answer your questions and help you understand your health care benefits

Get access to health and wellness programs

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



Why Blue Choice Select PPO Works

- **Access to a defined network of providers, including over 20,000 physicians and over 140 hospitals**
- **Access to a full range of participating ancillary services, such as home health care, hospice, private duty nursing, surgery centers and skilled nursing facilities**
- **No referrals needed for specialist care**
- **Health and wellness programs**
- **Web and mobile tools**

*Please note: Sangamon, Lawrence and Wabash counties are not included in the network.

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

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

The relationship between these vendors and BCBSIL is that of independent contractors. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by Blue365 discount program vendors. Members should contact the vendor directly with questions about the products or services offered by third parties.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
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Appendix B

Understanding Your Explanation of Benefits

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



THE EOB HAS THREE MAJOR SECTIONS:

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

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

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

THE EOB MAY INCLUDE ADDITIONAL INFORMATION:

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

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

bcbsil.com

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

Appendix B

BlueCross BlueShield of Illinois



Get the most from your benefits

A Benefits Value Advisor is like a tour guide, helping to point you in the right direction.

What can a Benefits Value Advisor (BVA) do?*

A BVA can help you save money on health procedures and tests, and also:

- Simplify complex benefit options, making them easier to understand
- Help you use your benefits more wisely and get better value

You'll get guidance for benefits such as medical, dental, pharmacy and other available coverage so you only need one call to get support. BVAs can also help you:

- Maximize your benefits
- Get cost estimates for various providers and procedures
- Help to schedule appointments
- Assist with referrals to clinical staff/programs
- Help with preauthorization

You can also access Provider Finder® to search for a network primary care physician, specialist or hospital. You can estimate the cost of hundreds of procedures, treatments and tests and your out-of-pocket expenses. Log in to your Blue Access for Members℠ (BAM℠) account and click on "Doctors and Hospitals." If you haven't registered, go to bcbsil.com, click the "Log In" tab and then click the "Register Now" link.

Which provider will you choose?

The same procedure performed in the same area by different providers can vary greatly in cost.

Estimated cost comparison for brain MRI	
Provider A: $977**	Provider B: $3,821**
Estimated cost comparison for a knee replacement	
Provider A: $15,837**	Provider B: $58,758**
Estimated cost comparison for a C-section	
Provider A: $11,156**	Provider B: $33,751**

Want to know more? See a video.

You may text keywords (MYBVA) to 33633 on your mobile phone to get more information and be directed to a video.

After texting the number, you'll receive a text that says, "BCBSIL: Get the most out of your health care with Benefits Value Advisor. You may save on out-of-pocket costs. More at http://bit.ly/benefitsbva."

* Benefits Value Advisors offer cost estimates for various providers, facilities and procedures. Lower pricing and cost savings are dependent on the provider or facility of your choosing. Member communications and information from Benefits Value Advisors are not meant to replace the advice of health care professionals. Members are encouraged to seek the advice of their doctors to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers. Cost estimates are just an estimate. In addition to your usual deductibles, copayments and/or coinsurance, the actual cost of the services may vary based on a number of factors including the date of service, the actual procedure performed and what services were billed by the provider and your particular benefit plan. Coverage is subject to the limitations, exclusions and terms of your plan.

** Allowable in-network cost data from Cook County. Costs are examples and may not be the same for every member's situation.

bcbsil.com One call can put you on a course for getting the most from your benefits. Call the number on the back of your member ID card before your next procedure.

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Appendix B

Find a dental provider

Guardian

It's easy to find a network dentist

We are committed to ensuring that you have the tools and resources to get the most from your benefits. This starts with making it easy to find a network provider. Remember, using a network dentist is one of the best ways to save on important care.

guardianlife.com

- Go to guardianlife.com
- Click "Find a dentist"
- Under "Dental benefits from your workplace" click "Find a dentist"
- Select plan type
- Enter your search parameters
- Customize your search by distance, specialty, and language spoken



Find a provider and ID card mobile app

- Search by name or location
- View results on a map and get directions
- View, print or email ID cards for use when scheduling an appointment or visiting a provider



Online or on the go — Guardian makes it easy to find a provider.

App Store

Google Play

The Guardian Life Insurance Company of America

guardianlife.com

New York, NY

Find a dental provider (10/25) NC

Dental Guard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only. Policy Form #GP-1-DG2000, et al. Guardian® is a registered trademark of The Guardian Life Insurance Company of America. ©Copyright 2023 The Guardian Life Insurance Company of America.

Appendix B

Find a vision provider

Guardian

It's easy to find a network vision provider

We are committed to ensuring that you have the tools and resources to get the most from your benefits. This starts with making it easy to find a network provider. Remember, using a network vision provider is one of the best ways to save on important care.

guardianlife.com

- Go to guardianlife.com
- Click "Find a vision provider"
- Select your vision network
- Select plan type
- Enter your search parameters
- Customize your search by distance, specialty, and languages spoken



Find a provider and ID card mobile app

- Search by name or location
- View results on a map and get directions
- View, print or email ID cards for use when scheduling an appointment or visiting a provider



Online or on the go — Guardian makes it easy to find a provider.

App Store

Google Play

The Guardian Life Insurance Company of America

guardianlife.com

New York, NY

Find a vision provider (10/25) NC

Guardian's Vision Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form No. GP-1-VSN-96-1 et al. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America® ©Copyright 2023 The Guardian Life Insurance Company of America.



Health Plan Participants

Naperville 203
Community Unit School District

Preventive Care Stay well and identify health concerns early. With an in-network physician preventive care services are **covered at 100%.** Recommended checkups and tests vary based on gender, age, last visit, or risk factors.

Wellness Portal **Reach your health goals** while having fun and earning **gift card rewards** with *Well onTarget*. Track your healthy habits, stay motivated, and participate in challenges as well as self management programs for stress, physical activity, nutrition weight management, specific health conditions and more.

Discounts Unlock **discounts** on health products, wellness programs and other services including discounted gym memberships, meal delivery, hearing and vision care, alterative medicine and virtual workouts with *Blue365*.

Virtual Physical Therapy With *Hinge Health* you can **recover from injury and pain** easy with virtual physical therapy using motion-tracking technology from home.

Women/Family Receive physical, emotional, financial and professional support through *Ovia* for **fertility, family building, maternity, parenting and menopause**.

Get Healthy In addition to virtual urgent care get help managing your **diabetes, cholesterol, hypertension, nutrition, dermatology, and mental health** with a personalized program as well as free devices such as smart scale, CGM, and/or blood pressure monitor with *Teladoc*.

Mental Health Access **therapy** to address areas of depression, stress, anxiety, worry, insomnia, and substance abuse with *Learn to Live*.

Member Rewards **Shop reward-eligible providers** for procedures and services like scans, colonoscopies, surgeries and more. Received a cash reward by check mailed to your home. Call the Benefits Value Advisor number on the back of your member ID card or bcbsil.com > provider finder.

Member Advocacy **Direct, unlimited access** to advocacy specialists to assist with the healthcare system: working with providers and insurance claims and benefits for your whole family. Mon-Fri 8AM-5PM CST
ILCHI-MAP@assuredpartners.com (800) 539-8147.

Marathon Health Center
Primary and mental health available at little to no cost at 1160 E. Ogden Avenue, Naperville, IL. Same and next day visits with little to no wait. Services include annual physicals, sick visits, condition management and labs as well as consultations for anxiety, depression, stress, substance abuse and more. (331) 226-0315 my.marathon.health

Hours
Monday, Wednesday – 7a – 5:30p
Tuesday, Thursday 7a-7p
Friday 7a – 12p

All Employees

Employee Assistance Program
In-person or over-the-phone support for a wide range of issues such as relationship issues, stress, depression/anxiety, addiction, grief, work-related conflicts, financial problem, legal difficulties and childcare. **Available to all employees and their families.** Guidanceresources.com (855) 239-0743

Access BlueCross resources online at www.bcbsil.com > wellness, or call the number on the back of your insurance card.

BCBSIL.COM

Member Advocacy

Navigating the world of healthcare is growing more challenging by the day. As a valued Naperville CUSD 203 employee enrolled in employer-sponsored benefits, you have access to AssuredPartners, a Gallagher Company Member Advocacy Program to give you the support you need when it matters the most.

Through this resource, you have unlimited access to advocacy specialists who understand the intricacies of the healthcare system and can help you with all your healthcare needs. Our team of experts is skilled in working with providers, insurance carriers and other health-related third parties to resolve claim and benefit issues to ensure you and your family get the right care at the right time.

The Member Advocacy Program offers year-round support with the following:

- Open Enrollment Assistance
- Questions on bills received from providers
- Identifying incorrectly processed claims
- Denied claims & authorizations
- Appeals & grievances
- Pharmacy & Rx assistance
- HSA, HRA & FSA reimbursement inquiries
- Expert claim review & analysis
- Clarifying benefits and explaining how they work
- Prior authorization and pre-certification process
- Navigating member portals
- Out of network claim submissions
- Locating network providers

Advocates are available to assist you Monday through Friday from 8am—5pm CST.



(800) 539-8147

ILCHI-MAP@assuredpartners.com

NOTE: This program is unable to assist with enrollments, terminations, eligibility, contributions (HSA, HRA, FSA, 401K) or retirement plans. Please contact HR for assistance.

NOTE: This Benefits Summary is merely intended to provide a brief overview of the Company's employee benefit programs. Employees should review the Company's employee handbook and actual plan documents for the precise terms of such programs. In the event of any inconsistency between this Benefits Summary and such governing documents, the governing documents will control. The Company reserves the sole and absolute discretion and right to interpret, apply, amend, discontinue or terminate, without prior notice, any and all of the benefit programs referenced herein.

Gallagher

Contact Information

If you have questions regarding health plans, coverage, providers, claims, billing or other related items, contact Member Advocacy at 1-800-539-8147 or email ILCHI-MAP@assuredpartners.com

If you have questions about accessing your benefit account, qualifying life events, updating your benefits or other related items, contact your Benefits Specialist.

Certified Staff and Administrators
Julie Budz
630.420.6325
jbudz@naperville203.org

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

Carrier Contact Information	Phone	Website
Priority Care – powered by Marathon Health (Near site health clinic on Ogden Ave)		
Priority Care	331.226.0315	my.marathon.health
Medical Carrier		
BCBSIL Members	1.800.458.6024	https://bcbsil.com/
In-Network Provider Finder		https://www.bcbsil.com/find-a-doctor-or-hospital
Prime Therapeutics – Prescription Drugs	1.800.423.1973	https://www.myprime.com
Benefit Value Advisor (BVA)	Call the number on the back of your ID card	
Utilization Review	Call the number on the back of your ID card	
Dental Carrier		
Guardian	1.888.600.1600	www.guardianlife.com
Vision Carrier		
Guardian	1.888.600.1600	www.guardianlife.com
Flexible Spending Account		
Inspira Financial	1.844.729.3539	https://www.inspirafinancial.com
Health Savings Account		
Lively	1.888.576.4837	https://www.livelyme.com
Basic and Voluntary Life Insurance Carrier		
Guardian	1.888.600.1600	www.guardianlife.com
Employee Assistance Program (EAP)		
ComPsych	1.855.239.0743	www.GuidanceResources.com Web ID: Guardian Mobile App: GuidanceNow
Telemedicine		
Teladoc Medical/Behavioral Health	1.800.835.2362	https://www.teladoc.com/ help@teladochealth.com
Retirement		
Omni 403(b)/457	1.877.544.6664	www.omni403b.com