Galesburg Community Unit School District 205

2025

Your Benefits, Your Choice

Employee Benefits Guide

BENEFIT HIGHLIGHTS

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WELCOME TO YOUR EMPLOYEE BENEFITS!

We understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. Within this guide, you will find the highlights of the benefits offered by the district.

Current Employees

Open Enrollment is your one chance per year to make changes to your benefit elections. Follow the steps on page 4 to log in to Employee Navigator to enroll or make changes to your benefit elections. Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

New Employees

This is your chance to elect benefits and enroll yourself and your eligible dependents. If you take no action now, you will have no benefits and you will not have another chance to elect them until next year's open enrollment—unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

VISIT THE MICROSITE BY CLICKING HERE

CONTACTS

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE
Medical	United Healthcare Surest Plan	1-833-719-1696 1-866-683-6440	www.myuhc.com www.benefits.Surest.com
Dental	Sun Life	1-800-862-6266	www.sunlife.com
Vision			
Group Life and AD&D			
Voluntary Life and AD&D			
Short/Long Term Disability			
Accident			
Critical Illness			
Hospital Indemnity			
Flexible Spending Account	EBC	1-800-346-2126	www.ebcflex.com
Medicare and Marketplace Assistance	Next Level Planning	1-262-395-2694	Email: Daniel.Fleming@nlpwm.com
Insurance Questions:	See Megan Kane at 309-973-2122		

The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the district.

ELIGIBILITY & ENROLLMENT

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits.

As a new employee, you have 30 days from your initial start date to enroll in benefits. Benefits will take effect date of hire.
**These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.*

Health Insurance Opt-Out Incentive

The district will offer employees a medical opt-out incentive of $810.31 per month. If you opt-out of the district health plan for 2025, you will receive $810.31 per month for 2025. In order to be eligible for this opt-out, you must be enrolled in the district health plan for the most recent 12 months (2024). Please check your collective bargaining agreement to see if your union is participating in this program. All employees exempt from collective bargaining agreements are eligible for this program.

Spouse Eligibility

The employee's legally married Spouse.

Child(ren) Eligibility

The employee's dependent children at the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.

Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.

Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

Open enrollment begins in December. The benefits you choose during open enrollment will become effective on 01/01/2025.

How to Make Changes

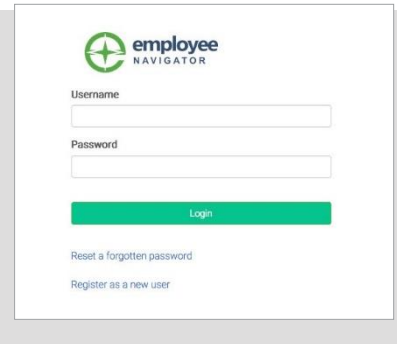
Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. Qualifying life events include things like:

- Marriage, divorce, legal separation, etc.
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan.

An election change must be made within 30 days of the qualifying event.

HOW TO ENROLL

Employee Navigator



Step 1: Log In

Go to www.employeenavigator.com and click **Login**

- Returning users: Log in with the username and password you selected. **Click Reset a forgotten password**.
- First time users: Click on your Registration Link in the email sent to you by your admin or **Register as a new user**. Create an account and create your own username and password.

Step 2: Welcome!

- After you login click **Let's Begin** to complete your required tasks.

Step 3: Onboarding (For first time users, if applicable)

- Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.
- **TIP:** *If you hit **"Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"***

Step 4: Start Enrollments

- After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.
- **TIP:** *Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.*

Step 5: Benefit Elections

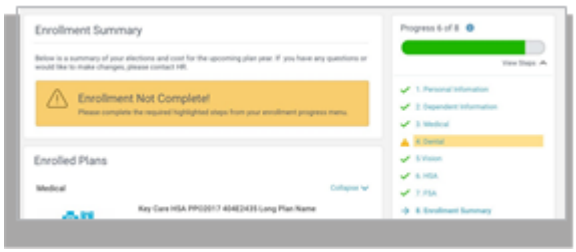
- To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**
- Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.
- Click **Save & Continue** at the bottom of each screen to save your elections.
- If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Start Enrollments

- If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Start Enrollments

- Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.
- **TIP:** *If you miss a step, you'll see Enrollment Not Complete in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.*



Step 8: HR Tasks (if applicable)

- To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

MONTHLY EMPLOYEE CONTRIBUTIONS

HEALTH COVERAGE	Surest Plan		PPO Plan		High Deductible Health Plan (HDHP)	
	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays	District Pays
Employee Only	$85.06	$810.31	$227.26	$782.49	$82.14	$782.49
Employee + Spouse	$1,069.96	$810.31	$1,337.98	$782.49	$1,033.23	$782.49
Employee + Child(ren)	$890.87	$810.31	$1,136.01	$782.49	$860.29	$782.49
Family	$1,875.77	$810.31	$2,246.73	$782.49	$1,811.37	$782.49
Family (2 District Spouses)	$1,065.46	$1,620.62	$1,464.24	$1,564.98	$1,028.88	$1,564.98

DENTAL & VISION COVERAGE*	Dental	Vision
	Full Insured Rate*	Fully Insured Rate*
Employee Only	$32.31	$7.23
Employee + Spouse	$64.64	$13.74
Employee + Child(ren)	$88.88	$14.47
Family	$131.85	$21.27
The School Board will contribute $70 towards the annual premium for each employee who elects to participate in the Vision and/or Dental Coverage. If both are selected, there will be an additional cost.		

LIFE/AD&D COVERAGE	Basic Life and AD&D	Voluntary / Term Life and AD&D
Employee Only	100% District-Paid	100% Voluntary – See Employee Navigator for Rates
Spouse	N/A	
Child(ren)	N/A	

DISABILITY COVERAGE	Voluntary Short & Long Term Disability
Employee Only	100% Voluntary – See Employee Navigator for Rates

INCOME PROTECTION COVERAGE	Accident, Critical Illness, & Hospital Indemnity
Employee Only	100% Voluntary – See Employee Navigator for Rates
Spouse	
Child(ren)	

If you have questions or concerns, please speak with Megan Kane at 309-973-2122.

HEALTH INSURANCE

United Healthcare

The district provides employees the option to purchase affordable medical coverage. Both plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider. Visit www.myuhc.com to find an in-network provider in the **United Healthcare Choice Plus network**.

HEALTH COVERAGE HIGHLIGHTS	**Surest Plan**		**PPO Plan**		**High Deductible Health Plan (HDHP)**	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
Individual	None	None	$1,500	$3,000	$3,300	$6,000
Family	None	None	$3,000	$6,000	$9,000	$18,000
Coinsurance (percent paid after you reach your annual deductible)						
Plans Pays	100%	100%	80%	60%	100%	80%
You Pay	0%	0%	20%	40%	0%	20%
Annual Out-of-Pocket Maximum						
Individual	$5,500	$11,000	$5,000	$10,000	$3,300	$7,000
Family	$11,000	$22,000	$9,000	$20,000	$9,000	$19,000
Covered Services						
Preventive Care	100% Covered	$190	100% Covered	40% after ded.	100% Covered	20% after ded.
Primary Care Office Visit	$20 to $125	$375	$25 Copay	40% after ded.	$0 after ded.	20% after ded.
Specialist Office Visit			$50 Copay	40% after ded.	$0 after ded.	20% after ded.
Virtual Visits	$0 to $125	Up to $375	No Cost	40% after ded.	$0 after ded.	20% after ded.
Urgent Care	$80	$240	$30 Copay	40% after ded.	$0 after ded.	20% after ded.
Emergency Room	$750		$200 Copay + 20% Coinsurance		$0 after ded.	
Hospitalization	See Benefit Summary		20% after ded.	40% after ded.	$0 after ded.	20% after ded.
PRESCRIPTION DRUG Coverage Highlights						
Prescription Drug Out-of-Pocket Maximum	Included in Medical		Included in Medical		Included in Medical	
Tier 1	$10		$10		$0 after ded.	
Tier 2	$35		$35		$0 after ded.	
Tier 3	$70		$70		$0 after ded.	
Tier 4 – Specialty*	$10 / $100 / $200		$400		$0 after ded.	

Make sure to ask your pharmacist about less expensive drug options and any available coupons

Please review the full plan documents for details including out-of-network coverage. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

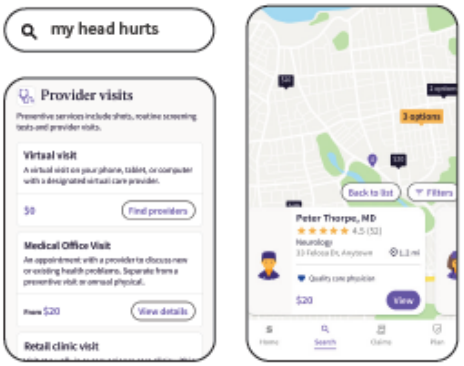
UHC SUREST PROGRAM

United Healthcare

Download the Surest app or visit Benefits.Surest.com to search for care and supplies — and see the price before you get them.

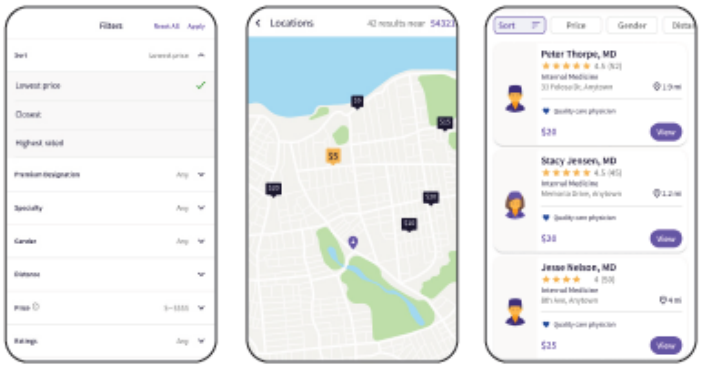
1 Search

- From the search bar, type in your condition, or symptoms like “my head hurts”.
- Results will show care options for you to consider.
- Select a doctor or location to see the copay.
- You can also search by provider name to see prices and if they’re in-network.



2 Compare

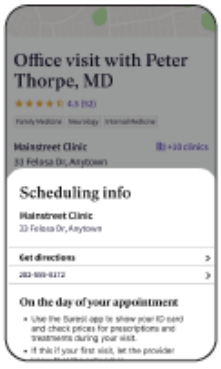
Turn on filters like specialty, gender, and distance to find care that suits you. Patient-submitted provider star ratings and reviews may also help you compare options.



3 Decide

By evaluating providers, locations, and costs in advance, you can make more informed decisions about care that fits your lifestyle and budget.

- View a map of provider listings to see upfront prices and nearby locations.
- Select the provider you want and see scheduling info.



Illustrative examples only. Cost and coverage may vary.

Questions about how to search?

Watch this video or contact Surest Member Services via chat, email, or phone at **866-683-6440, Monday – Friday from 6 am – 9 pm CT.**

VIRTUAL DOCTOR VISITS

United Healthcare

Telemedicine services can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. With 24/7/365 access to U.S. board-certified doctors, you can access medical care for only a small fee, from home or on the road—and in some cases, doctors can write a prescription to a local pharmacy near you.*



How Does It Work?

Log in to your account or register if you don't have one set-up. Then, contact UHC from anywhere—and let the doctor come to you!

UHC Virtual Visits

- **www.uhc.com/virtualvisits**

Doctors can then diagnose non-emergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.**Prescription services may not be available in all states.*

When Can I Use It?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.

Common Conditions We Treat

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore Throat
- Pink eye
- Urinary tract infections
- And more!

Save Money and Time!

Telemedicine provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

Meet Our Doctors!

- U.S. board-certified with an average of 15 years of practice experience
- U.S. residents and licensed in your state

DENTAL INSURANCE

Sun Life

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and x-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

For a complete list of your in-network and out-of-network benefits, please refer to your Dental Insurance Summary Plan Description, provided by the district.

Check out our short video for step-by-step instructions on downloading your dental ID card at **www.sunlife.com/dentalIDCard**. To find a dentist, **www.sunlife.com/findadentist.**

DENTAL COVERAGE HIGHLIGHTS	**In-Network**	Out-of-Network
Annual Deductible (Individual / Family)	$50 / $150	$100 / $300
Annual Benefit Maximum	$1,000	$750
Preventive Care	100% Covered	100% Covered
Basic Services	80% Covered	80% Covered
Major Services	50% Covered	50% Covered

Apple download

Android download

Please review the full plan documents for details including out-of-network coverage. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

VISION INSURANCE

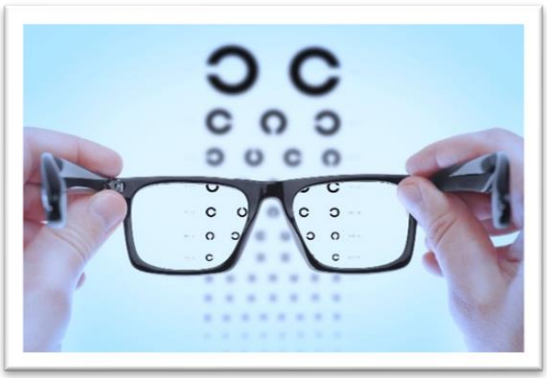
Sun Life

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. The district's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

For a complete list of your in-network and out-of-network benefits, please refer to your Vision Insurance Summary Plan Description, provided by the district.

Please also visit **www.vsp.com** or call **800-877-7195**

VISION COVERAGE HIGHLIGHTS	**In-Network**	Out-of-Network
Exam Once every 12 months	$10 Copay	Up to $45
Lenses Once every 12 months • **Single vision** • **Bifocal** • **Trifocal** • **Lenticular**	$25 Copay	Up to $30 Up to $50 Up to $60 Up to $100
Frames Once every 24 months	$130 Allowance	Up to $70
Contact Lenses Once every 12 months; in lieu of lenses/frames glasses • **Elective** • **Medically Necessary**	$130 Allowance 100% Covered	Up to $105 Up to $210



Please review the full plan documents for details including out-of-network coverage. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

BASIC LIFE/AD&D INSURANCE

Sun Life

Life insurance can help provide for your loved ones if something were to happen to you. The district pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

Your designated beneficiary will receive a benefit to help ease their financial burden if you die. If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically!

HOW MUCH LIFE INSURANCE COVERAGE DO YOU NEED?

Depending on your personal situation, you may wish to purchase additional coverage that you can buy at affordable group rates.

Use this worksheet to estimate how much additional life insurance you need and see the details of the voluntary life on the following page.

When considering how much life insurance you need, it's important to think about your outstanding debt, ongoing expenses and the future plans of your family. Fill in the blanks to figure out how much life insurance you may wish to purchase.

Outstanding Debt – How much will be left for your family to pay?	
Mortgage balance	$ _____
Other debt (credit cards, loans, car payment)	$ _____
TOTAL (A)	$ _____ (A)
Ongoing Expenses – How much do your dependents need each year?	
Utilities (electric, phone, cable, internet)	$ _____
Medical costs, insurance	$ _____
Food, clothing, gasoline	$ _____
Saving contributions	$ _____
TOTAL (B)	$ _____ (B)
Future Plans – How much will loved ones need for the future?	
College	$ _____
Other (retirement, long term care)	$ _____
TOTAL (C)	$ _____ (C)
Grand Total (A+B+C)	$ _____
Subtract existing coverage	$ _____
Subtract district-paid life	$ _____
Consider this amount of life insurance	$ _____

**AD&D pays a benefit for loss of life or dismemberment resulting from a covered accidental bodily injury. Your beneficiary may receive up to 100% of the AD&D amount if you die as the result of a covered accidental injury. You may receive an accidental dismemberment benefit for losses hand, a foot, or the sight of an eye due to an accidental injury. See the policy for exact schedule of losses and benefits.*

Please review the full summary plan documents for a list of your benefits, exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

VOLUNTARY LIFE/AD&D INSURANCE

Sun Life

Sun Life's Group Voluntary Term Life Insurance provides term life insurance at affordable group rates. Sun Life's Term Life Insurance can help protect your loved ones if you die during your working years. They can use it to help pay for housing and other expenses, including your final arrangements. If the plan includes an Accidental Death and Dismemberment (AD&D) benefit, the policy pays more money if you die in a covered accident. If you survive a serious accident, it can pay you money for certain severe injuries, such as loss of vision, hearing and limbs. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.

Summary of Benefits	
Term Life and AD&D Coverage Amounts	**Employee:** Lesser of $500,000 or 5x Earnings in increments of $10,000 **Spouse:** Up to $250,000 not to exceed 50% of employee amount, in increments of $5,000 **Child:** Up to $10,000
Guarantee Issue Amount – NO Health Questions	**Employee:** $150,000 **Spouse:** $30,000
Reduction Schedule	67% at 70 / 50% at 75
Additional Features	Education, Repatriation, Seatbelt, Airbag, Exposure

Important – Please Read!

- New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will in force when return to Active at Work/eligible status.
- Dependents may have a delayed effective date based on his/her medical status at time of enrollment. Please refer to the policy certificate or HR for more details.
- Please update your beneficiaries periodically! If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or HR for more information.

Please review the full summary plan documents for a list of your benefits, exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

DISABILITY INSURANCE

Sun Life

The district provides full-time employees with the opportunity to purchase short-term and long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits may provide a partial replacement of lost income. Please note, though, that you are not eligible to receive short-term disability benefits for work-related disabilities.

VOLUNTARY SHORT-TERM DISABILITY COVERAGE HIGHLIGHTS – COVERAGE CERTIFICATE	
Percentage of Income Replaced	60% of your weekly pre-disability earnings, up to a maximum of $1,500
Elimination Period If you suffer a qualifying disability, this is the length of time you must be continuously disabled before you can begin receiving your weekly benefit.	7 days
Benefit Duration	Up to 11 Weeks
Pre-Existing Condition Limitations	Conditions diagnosed or treated in the 3 months preceding the effective date of coverage are not covered for the first 12 months of the policy.

VOLUNTARY LONG-TERM DISABILITY COVERAGE HIGHLIGHTS – COVERAGE CERTIFICATE	
Monthly Benefit Amount	60% of your monthly pre-disability earnings, up to a maximum of $6,000 per month.
Elimination Period	90 days
Benefit Duration	Up to 5 Years
Pre-Existing Condition Limitations	Conditions diagnosed or treated in the 3 months preceding the effective date of coverage are not covered for the first 12 months of the policy.

Please review the full plan documents for plan details including exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

HOSPITAL INDEMNITY NOTICE

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

ADDITIONAL VOLUNTARY BENEFITS

Sun Life

The following voluntary benefits can work together with the Health Plans to help fill gaps in coverage and offset out-of-pocket medical costs. Coverage is available for yourself, spouse, and children. Please review rate information in Employee Navigator.

Critical Illness Insurance – Click HERE for more details

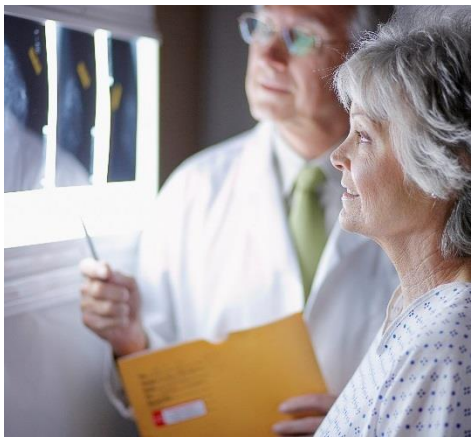
Critical Illness coverage pays an employee a lump-sum amount when diagnosed with a covered illness such as cancer, heart attack or stroke. Experiencing a critical illness can be devastating to you, your family, and your finances. This plan pays a lump-sum benefit that can be used for absolutely anything (deductible, paying bills, travel expenses, etc.). You can use this coverage more than once, even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer.

Accident Insurance – Click HERE for more details

Accident Insurance pays an employee specific amounts for covered accidents. Under the Accident plan if you suffer a covered accident (slipping on ice, car accident, etc.) you will receive a cash payment that varies depending on the injury and treatment course. The schedule of benefits covers accidental death and dismemberment, initial care, hospital care, follow-up care and injuries – ranging from lacerations to burns to broken bones. Coverage is available for yourself, spouse, and children.

Hospital Indemnity Insurance – Click HERE for more details

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The benefit is paid directly to you — not to a hospital or care provider. This money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.



Please review the full summary plan documents for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern*

FLEXIBLE SPENDING ACCOUNTS (FSA)

EBC

Paying for health care can be stressful. That's why the district offers an employer-sponsored FSA.

What Are the Benefits of an FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It saves you money**. Allows you to put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax-saver**. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. If you do not use it, you can continue to use funds elected for the year through the plans grace period. You should only contribute the amount of money you expect to pay out of pocket that year. **The maximum amount you may contribute each year to an FSA in 2025 is $3,300 per year**. **Note: Even if you signed up last year, you must re-enroll each year.**

What Is a Dependent Care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. **The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).**

FSA Case Study

Because FSAs provide you with an important tax advantage that can help you pay for health care expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

Bob and Jane's combined gross income is $30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $4,000 in medical expenses in the next plan year, they decide to direct a total of $3,300 (the maximum allowed amount per individual, for that taxable year) into their FSAs.

	Without FSA	With FSA
Gross income	$30,000	$30,000
FSA contributions	$0	-$3,300
Gross income	$30,000	$26,700
Estimated taxes		
Federal	-$2,550*	-$1,776*
State	-$900**	-$750**
FICA	-$2,295	-$1,913
After-tax earnings	$24,255	$22,261
Eligible out-of-pocket medical expenses	-$4,000	-$700
Remaining spendable income	$20,255	$21,561
Spendable income increase	--	$1,306

**Assumes standard deductions and four exemptions. **Varies, assumes 3 percent. This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice. Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.*

HEALTH SAVINGS ACCOUNT (HSA)

Available to employees enrolled on High Deductible Health Plan

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money.** HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable.** The money in your HSA is carried over from year to year and is yours to keep, even if you leave the district.
- **It is a tax-saver.** HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

HSA Contribution Limits

The maximum amount that you can contribute to an HSA in 2025 is $4,300 for individual coverage and $8,550 for family coverage. If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings.)

Year 1	
HSA Balance	$1,000
Total Expenses: - Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

➔

Year 2	
HSA Balance	$1,850
Total Expenses: - Office visits: $100 - Prescription drugs: $200 - Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

GET ADVICE ON ALTERNATIVE INSURANCE

Available to all employees – MEDICARE & MARKETPLACE

You May Be Eligible For Less Expensive Health Insurance

Request your FREE, personalized consult!

Every state offers a Health Insurance **Marketplace** (or "Exchange") for individuals to find affordable and quality health insurance. And **Medicare** is available to those 65 or older.

There may be more affordable or more generous coverage options for you and your family through other group health plan coverage (such as a spouse's plan), the Marketplace, Medicare or Medicaid.

Losing your employer coverage is a special enrollment event in the Marketplace. You could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (out-of-pocket costs for deductibles, coinsurance and copayments), and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll.

In addition, if you are approaching retirement, you may be asking yourself **"what are my Health Insurance options when I turn 65?"** Good news! The advisors at Next Level Planning can assist you with Medicare education and comparisons. They can help you decide if Medicare plan is right for you.

Examples of Subsidized Medical Plan Rates Available through HealthCare.gov:

Annual Household Income	Family Size	Subsidized Silver Plan Monthly Premium*	Family Size	Subsidized Silver Plan Monthly Premium*
$20,000	4	Medicaid (Free)	2	Medicaid (Free)
$40,000	4	$4	2	$133
$60,000	4	$158	2	$311
$80,000	4	$409	2	$567
$125,000	4	$885	2	$681

*Rates shown above are an example only, your specific rates will be determined based on your personal information. Silver coverage on the Exchange is approximately a $3,000 deductible plan.

Scan the QR code to submit your contact information. A representative at Next Level Planning will contact you to discuss or reach out directly to Jacob or Dan for assistance:

Is the Marketplace right for me?

Is Medicare Right For me?

- **Jacob Gustafson (Medicare)**
  Phone: 414-369-6628
  Email: jacob.gustafson@nlpwm.com
- **Dan Fleming (Marketplace)**
  Phone: 262.395.2694
  Email: daniel.fleming@nlpwm.com

PERKSPOT DISCOUNT PROGRAM

Through our partnership with Cottingham & Butler, we have access to the PerkSpot Employee Discount Program at no cost to you!

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL
- Founded in 2006
- 750+ clients nationwide
- 15 million members
- 30,000+ discount offers

Website Features

- **Recommended for You:** chosen based on your top interests
- **Featured Offers:** hand-selected to help you stretch your dollars
- **Today's Perk Alters:** today's best limited-time sales
- **Popular Savings:** trending offers
- **Categories:** shop by category
- **Local Discounts**: shop by location

Create Your Account

1. Visit www.cottinghambutler.perkspot.com
2. Click "Create an Account"
3. Enter your Name, Email, Gender, Zip Code and create a Password
4. Sign up for email updates
    a. **Weekly Perks:** Stay up to date on the best discounts and exclusive offers available to you
    b. **theLOOP:** PerkSpot's weekly resource for how to excel in the 21st century workplace. Providing insights into workplace trends, lifestyle practices, and strategies for success
5. Click "**Register**"
6. Browse discount offers from over 25 categories

Shop for a Variety of Coupons & Deals from these Categories:

- Apparel
- Auto Buying
- Automotive
- Beauty & Fragrance
- Books, Movies, & Music
- Business Perks
- Cell Phones
- Education
- Electronics
- Financial Wellness
- Flowers & Gifts
- Food
- Health & Wellness
- Hobbies & Creative Arts
- Home & Garden
- Home Services
- Insurance & Protection Services
- Jewelry & Watches
- Movie Tickets
- Office & Business
- Pets
- Real Estate & Moving Services
- Sports & Outdoors
- Tickets & Entertainment
- Toys, Kids & Babies
- Travel

Popular Discounted Brands*:

- Avis
- Canon
- Casper
- Columbia
- Dell
- Enterprise
- Holiday Inn
- Home Chef
- HP
- Ray-Ban

**All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at www.cottinghambutler.perkspot.com*

IN-NETWORK VS OUT-OF-NETWORK CARE

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Getting the Most Out of Your Care

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even through the primary physician is in-network.

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

Preventive Care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

In-network Bill

Provider	Network	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	Appropriate discount for using an in-network provider is applied.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Out-of-network Bill

Provider	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

Annual limit—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.

Claim—A bill for medical services rendered.

Cost-sharing—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.

Coinsurance—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
Example: John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80 percent of the remaining cost, for a total of $2,400. John will still be responsible for 20 percent, or $600, of the remaining cost. The total John must pay for his second surgery is $800.

Copayment (copay)—A fixed amount you pay for a covered health care service, usually when you receive the service.

Deductible—The amount you owe for health care services each year before the insurance company begins to pay. *Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.*

Dependent Coverage—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.

Explanation of Benefits (EOB)—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.

Group Health Plan—A health insurance plan that provides benefits for employees of a business.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Inpatient Care—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.

Insurer (carrier)—The insurance company providing coverage.

Insured—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.

Open Enrollment Period—Time period during which eligible persons may opt to sign up for coverage under a group health plan.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Out-of-pocket Maximum (OOPM)—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.

Outpatient Care—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.

Policyholder—The individual or entity that has entered into a contractual relationship with the insurance carrier.

Premium—Amount of money charged by an insurance company for coverage.

Preventive Care—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
Provider—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.

Qualifying Life Event—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.

Qualified Medical Expense—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

Summary of Benefits and Coverage (SBC)—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

ACA—Affordable Care Act

CDHC—Consumer driven or consumer directed health care

CDHP—Consumer driven health plan

CHIP—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.

CPT Code—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.

FPL—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.

FSA—Flexible spending account. An employer-sponsored savings account for health care expenses.

HDHP—High deductible health plan

HMO—Health maintenance organization

HRA—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.

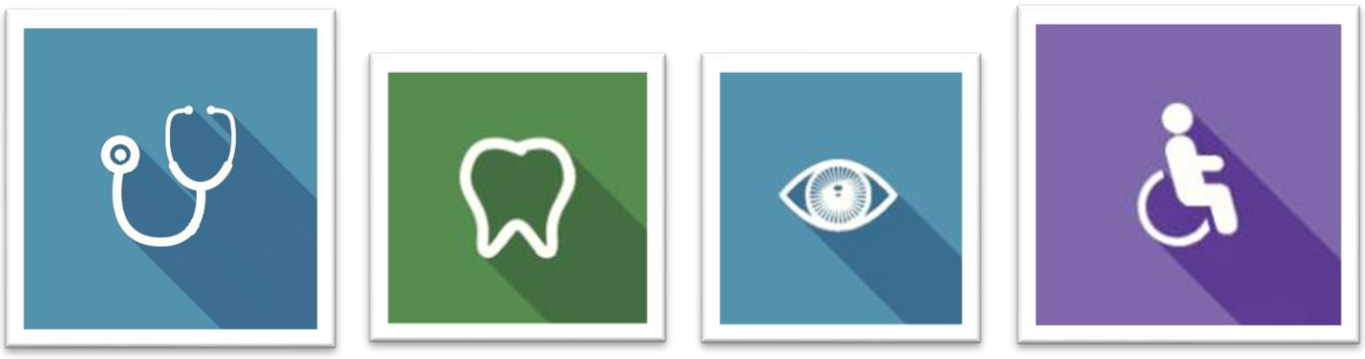
HSA—Health savings account. A tax-advantaged savings account that accompanies HDHPs.

OOP—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.

PCE—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.

PPO—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.

QHP—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.



Galesburg CUSD #205 Health & Welfare Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

If an Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer plan, the employer must allow the Employee to enroll in the employer plan if they are not already enrolled. This is called a "special enrollment" opportunity, and **the Employee must request coverage within 60 days of being determined eligible for premium assistance.** If the Employee has questions about enrolling in the employer's plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2024. V 0.4.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or
www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565 ❖

Patient Protection Notice

If the Galesburg CUSD #205 Health & Welfare Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain

benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled. The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 8.39% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources. The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or

2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The Galesburg CUSD #205 Group Medical Plan (the "Plan"), which includes medical, dental, vision, FSA, HSA and additional coverages offered under the Galesburg CUSD #205 Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Galesburg CUSD #205 has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Galesburg CUSD #205 is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written

authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Galesburg CUSD #205, 932 Harrison St Galesburg, Illinois 61401, 309-343-3623. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Galesburg CUSD #205 Health & Welfare Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your

current prescription drug coverage with Galesburg CUSD #205 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. Galesburg CUSD #205 has determined that the prescription drug coverage offered by the Galesburg CUSD #205 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 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) 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 Galesburg CUSD #205 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Galesburg CUSD #205 coverage, be aware that you and your dependents will be able to get this coverage back.

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 with Galesburg CUSD #205 and don't 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.

If you go 63 continuous days or longer 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, if you go nineteen 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 the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Galesburg CUSD #205 changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get 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 (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- 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 paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: 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).

Date: 11/18/2024
Name of Entity/Sender: Galesburg CUSD #205
Contact--Position/Office: Human Resources
Address: 932 Harrison St Galesburg, Illinois 61401
Phone Number: 309-343-3623