



April 1, 2024 – March 31, 2025

All Active Employees  
Health Insurance Program Guide



PPO Plan		HMO Plans		HSA Plan	
Network Benefits	Non-Network Benefits	HMO IL & Blue Advantage Network Benefits		Network Benefits	Non-Network Benefits
Plan Deductible		Plan Deductible		Plan Deductible	
\$500 Individual Combined \$1,500 Family Combined		None		\$1,600 Individual \$3,200 Family	\$3,000 Individual \$6,000 Individual
Coinsurance		Coinsurance		Coinsurance	
You 20%, Plan 80%	You 40%, Plan 60%	Plan 100%		You 20%, Plan 80%	You 40%, Plan 60%
Out-of-Pocket Maximum		Out-of-Pocket Maximum		Out-of-Pocket Maximum	
<i>Deductible, ER Copay, Coinsurance Applies</i>		<i>Physician, Specialist, ER Copays Applies</i>		<i>Deductible, Coinsurance Applies</i>	
\$2,000 Individual \$6,000 Family	\$10,000 Individual \$30,000 Family	\$1,500 Individual \$3,000 Family		\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 Individual
Rx Out-of-Pocket Maximum		Rx Out-of-Pocket Maximum		Rx Out-of-Pocket Maximum	
<i>RX Copays Apply</i>		<i>RX Copays Apply</i>			
\$1,000 Individual \$2,000 Family	No Maximum No Maximum	\$1,000 Individual \$2,000 Family		Subject to the Above Out-of-Pocket Maximum	
Preventive Health Screenings		Preventive Health Screenings		Preventive Health Screenings	
100%	60% after Deductible	100%		100%	60% after Deductible
Physician Office Visit		Physician Office Visit		Physician Office Visit	
80% after Deductible	60% after Deductible	100% after \$20 Copay		80% after Deductible	60% after Deductible
Specialist Office Visit		Specialist Office Visit		Specialist Office Visit	
80% after Deductible	60% after Deductible	100% after \$40 Copay		80% after Deductible	60% after Deductible
Emergency Room Services		Emergency Room Services		Emergency Room Services	
100% after \$150 Copay (Waived if Admitted)		100% after \$150 Copay (Waived if Admitted)		90% after Deductible	
Inpatient Hospital Services		Inpatient Hospital Services		Inpatient Hospital Services	
80% after Deductible	60% after Deductible	100%		80% after Deductible	60% after Deductible
Outpatient Hospital Services		Outpatient Hospital Services		Outpatient Hospital Services	
80% after Deductible	60% after Deductible	100%		80% after Deductible	60% after Deductible
Outpatient Surgical/Diagnostic Services		Outpatient Surgical/Diagnostic Services		Outpatient Surgical/Diagnostic Services	
80%	60%	100%		80% after Deductible	60% after Deductible
Hospital Admission Deductible		Hospital Admission Deductible		Hospital Admission Deductible	
None		None		\$0	\$300
Prescription Drugs		Prescription Drugs		Prescription Drugs	
Retail Copays: Generic: \$10 Brand Preferred: \$30 Brand Non-Preferred: \$50	Retail: 75% of the In-Network Charge After Copay	Retail Copays: Generic: \$10 Brand Preferred: \$30 Brand Non-Preferred: \$50		Retail: 80% After Deductible	Retail: 75% of the In-Network Charge After Coinsurance
Mail Order Copays: Generic: \$20 Brand Preferred: \$60 Brand Non-Preferred: \$100	Mail Order: Not Covered	Mail Order Copays: Generic: \$20 Brand Preferred: \$60 Brand Non-Preferred: \$100		Mail Order: 80% After Deductible	Mail Order: Not Covered
<b>Program Contact Information</b>		<b>Program Contact Information</b>		<b>Program Contact Information</b>	
PPO Customer Service: (800) 458-6024 Pharmacy Customer Service: (800) 423-1973 BCBS Home Page: www.bcbsil.com		HMO Customer Service: (800) 892-2803 Pharmacy Customer Service: (800) 423-1973 BCBS Home Page: www.bcbsil.com		PPO Customer Service: (800) 458-6024 Pharmacy Customer Service: (800) 423-1973 BCBS Home Page: www.bcbsil.com	

**April 1, 2024 thru March 31, 2025 - PAYROLL DEDUCTIONS EFFECTIVE 4/05/24 - ALL FULL-TIME STAFF MEMBERS BENEFIT ELIGIBLE**

Health Insurance	Billed Premium		BOE Paid %	Employee Cost* <i>BCBS Credit Applied</i>		
	Monthly	Annual		Monthly	Annual	Per Pay (24 Total)
PPO Employee	\$ 1,007.83	\$ 12,093.96	95%	\$ 49.69	\$ 596.28	\$ 24.85
PPO Employee + One Dependent	\$ 1,756.34	\$ 21,076.08	80%	\$ 346.38	\$ 4,156.56	\$ 173.19
PPO Employee + All Dependents	\$ 2,671.72	\$ 32,060.64	75%	\$ 658.63	\$ 7,903.56	\$ 329.32
HMO IL Employee	\$ 818.43	\$ 9,821.16	95%	\$ 40.35	\$ 484.20	\$ 20.18
HMO IL Employee + One Dependent	\$ 1,503.54	\$ 18,042.48	80%	\$ 296.52	\$ 3,558.24	\$ 148.26
HMO IL Employee + All Dependents	\$ 2,285.97	\$ 27,431.64	75%	\$ 563.53	\$ 6,762.36	\$ 281.77
HMO Blue Advantage Employee	\$ 762.20	\$ 9,146.40	95%	\$ 37.58	\$ 450.96	\$ 18.79
HMO Blue Advantage Employee + One Dependent	\$ 1,399.50	\$ 16,794.00	80%	\$ 276.00	\$ 3,312.00	\$ 138.00
HMO Blue Advantage Employee + All Dependents	\$ 2,127.17	\$ 25,526.04	75%	\$ 524.39	\$ 6,292.68	\$ 262.20
HSA Employee	\$ 885.87	\$ 10,630.44	95%	\$ 43.68	\$ 524.16	\$ 21.84
HSA Employee + One Dependent	\$ 1,450.18	\$ 17,402.16	80%	\$ 286.00	\$ 3,432.00	\$ 143.00
HSA Employee + All Dependents	\$ 2,204.37	\$ 26,452.44	75%	\$ 543.42	\$ 6,521.04	\$ 271.71

*This Benefit Guide is a highlight of coverages. For a complete description, refer to the plan certificates. The plan documents will govern in all cases.*

**Dental Benefits are Insured by: BlueCross BlueShield of Illinois**



PPO Dental Plan	
Network Benefits	Network Benefits
Calendar Year Maximum	
\$1,000 Per Individual	
Calendar Year Deductible	
\$50 Per Individual: \$150 Per Family (Waived For Preventive Services )	
Preventive Services	
100% of Maximum Plan Allowance	100% of Usual and Customary
Basic Services	
80% of Maximum Plan Allowance	80% of Usual and Customary
Major Services	
50% of Maximum Plan Allowance	50% of Usual and Customary
Orthodontia Services For Dependent Children to Age 19	
50% of Maximum Plan Allowance	50% of Usual and Customary
Orthodontia Lifetime Maximum	
\$750 Per Individual	
HMO / BlueCare 630 Plan Network Benefits: Refer to DMO Copay Schedule	
Policy Contact Information: Home Page: <a href="http://www.bcbsil.com">www.bcbsil.com</a> Customer Service: (800) 367-6401	

**April 1, 2024 thru March 31, 2025 - PAYROLL DEDUCTIONS EFFECTIVE 4/05/24 - ALL FULL-TIME STAFF MEMBERS BENEFIT ELIGIBLE**

Dental Insurance	Billed Premium		BOE Paid %	Employee Cost		
	Monthly	Annual		Monthly	Annual	Per Pay (24 Total)
PPO Employee	\$ 42.61	\$ 511.32	95%	\$ 2.13	\$ 25.57	\$ 1.07
PPO Employee + One Dependent	\$ 91.03	\$ 1,092.36	80%	\$ 18.21	\$ 218.47	\$ 9.10
PPO Employee + All Dependents	\$ 138.92	\$ 1,667.04	75%	\$ 34.73	\$ 416.76	\$ 17.37
HMO / BlueCare 630 Employee	\$ 37.25	\$ 447.00	95%	\$ 1.86	\$ 22.35	\$ 0.93
HMO / BlueCare 630 Employee + One Dependent	\$ 68.97	\$ 827.64	80%	\$ 13.79	\$ 165.53	\$ 6.90
HMO / BlueCare 630 Employee + All Dependents	\$ 119.34	\$ 1,432.08	75%	\$ 29.84	\$ 358.02	\$ 14.92

**Vision Benefits are Insured by: EyeMed**



PPO Plan	
Network Benefits	Out-of-Network Benefits
Benefit Frequency	
Exam: Every 12 Months; Lenses/Contact Lenses Every 12 Months; Frames: Every 24 Months	
Exams	
\$10 Copay	Up to \$40 Max Reimbursement
Lenses	
\$25 Copay	Single: Up to \$30; Bifocal: Up to \$50; Trifocal & Lenticular: Up to \$70 Max Reimbursement
Frames	
\$0 Copay up to \$130 Allowance, 20% off Remaining Balance	Up to \$91 Max Reimbursement
Contact Lenses	
Fitting: Standard: \$40 Copay; Premium: 10% off Retail	Fitting: Not Covered
Lenses: \$0 Copay up to a \$130 Allowance	Lenses: Up to \$130 Max Reimbursement
Policy Contact Information: Home Page: <a href="http://www.eyemed.com">www.eyemed.com</a> ; Customer Service: (866) 939-3633	

**April 1, 2024 thru March 31, 2025 - PAYROLL DEDUCTIONS EFFECTIVE 4/05/24 - ALL FULL-TIME STAFF MEMBERS BENEFIT ELIGIBLE**

Vision Insurance	Billed Premium		BOE Paid %	Employee Cost		
	Monthly	Annual		Monthly	Annual	Per Pay (24 Total)
PPO Employee	\$ 5.76	\$ 69.12	0%	\$ 5.76	\$ 69.12	\$ 2.88
PPO Employee + Spouse	\$ 10.95	\$ 131.40	0%	\$ 10.95	\$ 131.40	\$ 5.48
PPO Employee + Child(ren)	\$ 11.52	\$ 138.24	0%	\$ 11.52	\$ 138.24	\$ 5.76
PPO Employee + Family	\$ 16.94	\$ 203.28	0%	\$ 16.94	\$ 203.28	\$ 8.47

**Life AD&D Benefits are Insured by: BlueCross BlueShield of Illinois**



Life Insurance
<b>Basic Life AD&amp;D:</b> Contingent Upon Employment Contract. Reduces 50% at Age 70; Terminates at Retirement.
<b>Employee Voluntary Life:</b> Increments of \$10,000 to the Lessor of \$500,000 or 5 x Earnings. Terminates at Retirement
<b>Spouse Voluntary Life:</b> Increments of \$10,000 to the Lessor of \$250,000 or 50% the Employee's Benefit. Terminates at Retirement
<b>Dependent Child(ren) Voluntary Life:</b> 15 Days to 6 Months: \$1,000; 6 Months to Age 20 (26 FT Student): Increments of \$2,500 to \$10,000
Policy Contact Information: Home Page: <a href="http://www.bcbsil.com/ancillary/employees">www.bcbsil.com/ancillary/employees</a> / Customer Service: (800) 367-6401

**Employee Assistance Program (EAP) is Provided by: Workplace Solutions**



Employee Assistance Program
Face to Face Counseling Sessions: 6 Per Episode / Telephonic Counseling & Internet Resources: Unlimited
Username for Work-Life & Legal-Financial Portal: ArborPark / Access Code for Lifespeak OnDemand Portal: Lifespeak
Contact Information: Home Page: <a href="http://www.wseap.com">www.wseap.com</a> / Customer Service: (877) 215-6614



## YOUR EMPLOYEE BENEFITS

Arbor Park School District 145 is pleased to offer to you and your family our comprehensive benefits program. Our benefits program contains a variety of plans intended to enhance your life and those of your family members now and in the future. As part of this benefits program, you will be asked to make choices about the benefits described in this booklet.

### Highlights of Your Benefits

- Contributory Medical & Prescription Drug Coverage
  - BCBSIL PPO Plan
  - BCBSIL HMO IL Plan
  - BCBSIL HMO Blue Advantage Plan
  - BCBSIL HSA Plan
- Contributory Dental Coverage
  - BCBSIL Dental PPO Plan
  - BCBSIL Dental HMO Plan
- Voluntary Vision Coverage
- Non-Contributory Basic Life and Accidental Death & Dismemberment (AD&D) Coverage
- Voluntary Supplemental Life AD&D Coverage
- Voluntary Dependent Life AD&D Coverage
- Employee Assistance Program (EAP)

### Eligibility

**Medical, Dental, Vision, Life AD&D, Voluntary Supplemental & Dependent Life AD&D** All full-time employees regularly scheduled to work at least 30 hours per week are eligible to participate in our benefits plan. Employee's benefits will become effective on the date of hire. In addition to covering yourself, you may also choose to cover dependents including your spouse, civil union partner, domestic partner and eligible dependent children.

## MEDICAL

**Medical** The District's medical coverage is provided by BlueCross BlueShield of Illinois (BCBSIL).

**BCBSIL PPO** Preferred Provider Organization (PPO) offers an extensive national network of physicians and hospitals that have agreed to provide services at discounted rates. You may visit any doctor in any practice or specialty without a referral, but you are covered at a higher level if you receive care from a provider in the BCBS network rather than outside of the network.

**HMO IL & BlueAdvantage HMO** An HMO plan is available with the choice of two HMO provider networks: HMO Illinois and Blue Advantage. The HMO Illinois network has a slightly larger scope of network providers. The HMO plans require that you select a medical group and primary care physician (PCP) from the BCBSIL directory. Covered females may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. All care must be provided or coordinated by your PCP, WPHCP or medical group.

**BCBSIL HSA** Health Savings Account (HSA) offers the same network of physicians and hospitals as the PPO. Additionally, you may also visit any doctor, in any practice or specialty without a referral and like the PPO you are covered at a higher level if you receive care from a BCBS in-network provider. You may establish a tax advantaged account to help pay for a variety of medical expenses incurred.



## DENTAL

**Dental** Our dental PPO plan is provided through BCBSIL. The dental PPO works in the same way as the medical PPO in that you will receive the maximum benefits if you receive care from a PPO in-network dentist. While you may still be covered if you choose an out-of-network dentist, those benefits may be reduced. We also offer a DMO plan which allows you to seek services at an in-network provider at a set copayment.



## VISION

**Vision** Our voluntary vision plan is provided by EyeMed. By visiting in-network providers you will pay a copay and any applicable amounts after your allowance for materials and services. When visiting out of network providers, you may be eligible for a reimbursement.



## LIFE AD&D

**Life and AD&D** To financially assist families in the unfortunate event of an employee's loss of life, the District provides employees with basic term life insurance through BlueCross BlueShield of Illinois at no cost. An additional benefit may be payable for accidental death or non-work-related dismemberment.

**Voluntary Supplemental Life** In addition to the basic term life insurance benefit the District provides employees the opportunity to purchase additional amounts of Life and AD&D insurance. The District also provides employees the opportunity to purchase life insurance for spouses and dependent child(ren).



## EMPLOYEE ASSISTANCE

**EAP** An Employee Assistance Program is provided by Workplace Solutions at no cost to you. The EAP provides a variety of expert support services to assist with day-to-day life issues.



## QUESTIONS?

If you have any additional questions, please contact the District's human resources department.