Chicago Public Schools

Health and Benefits Handbook 2022

The Best Care at the Best Value

Welcome to the Chicago Public Schools. As a vital part of our students' futures, it is important to us that you maintain your health, energy and peace of mind and are able to be your best each day. We are pleased to offer employees a comprehensive health and wellness benefits package with digitally enhanced tools and mobile access customizable to the way you live. We encourage you to do more than skim this guide; read it thoroughly and learn how to access perks such as discounts on gym memberships for the whole family; wellness and stress management coaching; and financial and legal services through the Employee Assistance Program (EAP). In the guide, you'll also find out how to earn points for your healthy actions and redeem them for prizes through the new Well on Target wellness program by Blue Cross Blue Shield of Illinois (BCBSIL).

We're in this together! Our benefits specialists are eager to assist, answer your questions and help you make the most of your benefits.

The information in this handbook is effective January 1, 2022, except as otherwise noted.

Nothing in this handbook should be interpreted as creating an employment contract, binding agreement or agreement to continue employment or as a guarantee of employment. The Board retains the right to modify, amend, suspend or terminate the benefit plans at any time.

The plans, benefits and coverage described in this handbook are subject to change at the sole discretion of the Board. The Health and Benefits Team will provide notice of changes through email or other means; however, such changes will have effect regardless of whether notice is given or received. If there is a conflict or inconsistency among the benefits and requirements summarized in this handbook and the actual plan documents and contracts, the documents and contracts will govern. This handbook is not intended to substitute, replace, overrule or modify any existing federal and state laws, agency rules, regulations or terms of a collective bargaining agreement (if applicable).

The Board currently intends to maintain the various plans that comprise the benefits program. But the Board retains the right to amend or terminate any plan or benefit to the fullest extent allowed by law at any time, as it deems advisable, as to any or all of the employees, retirees, former employees or other participants or beneficiaries who are or may become covered. The Board periodically reevaluates the benefits program. Any changes to the plans may be more or less advantageous to a given employee than the provisions of the current plans. The Board, in its sole discretion, may establish the effective date for any changes that are formally adopted.

The final interpretation of this handbook's provisions is the exclusive responsibility of the Board of Education of the City of Chicago. If you have additional questions, you may call the Health and Benefits Team at (773) 553-HR4U (4748) from 9:00 a.m. to 4:00 p.m. Monday through Friday. Additional information is online at **CPS.edu/Staff then click on the link for HR4U.** Correspondence may be directed to:

Board of Education of the City of Chicago
Attention: Health and Benefits
2651 W. Washington Blvd.
Chicago, IL 60612

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Revised 2022-01

Eligibility

Timing is critical. If you do not enroll in benefits coverage within 31 days of your hire date or during open enrollment, you will have to wait until the next Open Enrollment. Coverage would take effect January 1 the following year.

Group Benefits: Who Qualifies for Coverage

Employees of the Board/CPS who work at least 30 hours each week, have Full-Time status or are a regularly assigned teacher, other than temporary or seasonal.	Employees of the Board/CPS who are represented by Local No. 1 or Local No. 73 and who regularly work at least 15 hours each week.	Employees of the Board/CPS who are represented by the CTU and who regularly work at least 15 hours each week.

Dependents

When dependent coverage is available, benefits-eligible employees can elect to cover their…

- Legal spouse or civil union partner.
- Dependent children under the age of 26, including natural children, stepchildren, legally adopted children and/or children under the employee's legal guardianship.
- Dependent children ages 26 to 30 who were honorably discharged from the military and reside in Illinois. For information relating to cost see page 11.
- Children of any age who depend on the employee because of physical or mental handicap, if they were covered and adequate documentation of disability was submitted to and approved by the Health and Benefits Team prior to the child's 26th birthday.

New hires and employees electing coverage due to a family status change may add disabled dependents age 26 and older when electing coverage for the first time, and the age limit for submitting documentation does not apply.

The employee must provide proof that the child was disabled prior to the child's 26th birthday, and that the child was continuously covered by group health coverage since the child's 26th birthday.

Dual Eligibility

An eligible employee cannot be covered under any Board-sponsored plan as both an employee and a dependent. If both you and your spouse are employed by the Board, you choose one of two options:

- One employee enrolls as the other employee's dependent.
- Each employee enrolls for individual coverage.

In either option you may also enroll your dependent children (but children may not be enrolled by both parents in Board-sponsored plans).

Leaves of Absence (LOA) and Employee Benefits

Some leaves of absences (LOA) may allow an employee to continue receiving benefits. If you are planning an LOA, you should contact the Absence and Disability Management Department before your leave or as soon as possible to confirm your eligibility to continue any benefit. When you return from your LOA you must verify your benefit status with the Health and Benefits Team within 31 days of your return to avoid a possible lapse in your coverage. If your benefits were discontinued during your LOA, you may re-enroll for benefits within 31 days of your return from your LOA, provided that you are eligible for coverage. **Coverage is not automatic.** While on an LOA, you are still responsible for payment of your benefits. If you are not receiving a paycheck, you will be sent a monthly invoice for payment.

Changing Coverage

You will have the opportunity to change coverage for yourself and/or your dependents during Open Enrollment each year. The change will take effect the following January 1. Dependents can be added within 31 days of a qualifying event, such as a marriage or birth of a child, with coverage effective immediately. (For eligibility see Family Status Change.)

Because of favorable tax treatment you receive by paying for certain benefits on a pre-tax basis, the IRS requires strict compliance with Section 125 of the Internal Revenue Service Code, which governs when changes are allowed. If you think you have a qualifying family status change, immediately contact the Health and Benefits Team for more information.

Coverage for you and your eligible dependents will cease:

- If the plan is discontinued
- If you fail to pay premiums for the plan
- If you no longer meet the eligibility requirements to participate in the plan
- When you are no longer part of an employee group covered by this plan
- On the last day of the month in which your employment terminates.

Family Status Change

If you have a qualifying Family Status Change during the year, you may change coverage within 31 days of the event. Documentation is required. Do not wait until you receive the document(s), however, to notify the Health and Benefits Team. Completion of your enrollment must occur within the 31-day period. Any change in coverage must be consistent with the change in family status.
Below are some of the most common triggers.

Legal Marital Status	Employment Status	Number or Status of Dependents
Marriage, divorce, establishment/ termination of a civil union, termination of an existing grandfathered domestic partnership, death.	Your spouse/civil union partner/ dependent child(ren) gains or loses coverage; or employment ends or starts for the employee, spouse or dependent that affects benefits eligibility.	Birth, adoption, placement for adoption or death of a dependent; change in age or other qualifying criterion of dependent.
Domestic Relations Orders	**Work Schedule**	**Medicare and Medicaid**
A court order resulting from a divorce, legal separation, annulment, or change in legal custody that requires health plan coverage for the employee's child under the employee's health plan, or that requests the employee's former spouse to provide the coverage.	A switch between part-time and full-time work, a strike or lockout, commencement of or return from an unpaid leave of absence, or an increase or decrease in hours of employment by the employee, spouse or dependent that affects benefits eligibility.	A corresponding change is permitted under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) due to the employee's, spouse's, or dependent's gain or loss of Medicare or Medicaid eligibility.

Any enrollment changes will take effect as of the date the event occurred if you properly notify the Health and Benefits Team within 31 days of the event. Otherwise, your next chance to change coverage will be during Open Enrollment, with the change taking effect the following January 1.

Fraudulent Acts

The district considers submission of documents falsifying a person's eligibility to obtain healthcare coverage an act of fraud. Similarly, failing to notify the Chicago Public Schools that a formerly eligible person (spouse, child, civil union or domestic partner) is no longer eligible within 31 days of the date that person became ineligible is an act of fraud. Suspicious acts will be reported to the Office of the Inspector General and are grounds for termination. The employee will also be held responsible for any PPO claims or HMO premiums paid on behalf of an ineligible person.

Enrollment

If you are eligible for benefits, you may elect coverage for yourself, your spouse, civil union partner and children, provided they all meet eligibility criteria. Remember, you must submit any required proof of dependency within 31 days of your date of hire. Please log in to **CPS.edu/Staff then click on the link for HR4U** for more information to complete your benefits enrollment.

Coverage Levels

Yourself (employee only)

You and your legal spouse or one child (employee + one)

You, your legal spouse and one or more children (family)

If You Don't Enroll

If you do not enroll for coverage within 31 days after your hire date or during Open Enrollment, while there are some very limited exceptions (e.g., if you lose coverage due to a spouse's loss of work), you will not be able to enroll until the next Open Enrollment and your coverage will not take effect until the following January 1. Also, if you decline coverage, you and your eligible dependents will be ineligible to continue coverage under COBRA if you leave CPS employment or experience any other qualifying event.

Cost

CPS pays a substantial portion of the cost of your medical care plan. Your share of the cost is deducted from your paycheck, as a percentage of your salary, on a pre-tax basis, according to Sections 105, 106 and 125 of the Internal Revenue Service Code. As result, your taxable income will be reduced by the amount of your premiums. You won't pay any federal or state taxes (or Medicare taxes if they apply) on your premiums. Contact the Health and Benefits Team for information about the current cost of coverage. Medical costs are subject to change each year.

Enrolling Dependents

If you wish to enroll an eligible dependent in a Board-sponsored benefit plan, you must submit the documents specified below as proof of dependency. To ensure proper identification of your documents, you must use your personalized cover sheet along with all of the pertinent documentation. It can be downloaded from **CPS.edu/Staff then click on the link for HR4U**. Your spouse or dependent cannot be enrolled if identifying information is not included with your documents.

Spouse
Documentation Required: Marriage Certificate

- Submit a county-certified copy of your marriage certificate. Keep in mind the following: Marriage licenses are acceptable only if they also have a certification of the date that the county clerk recorded the marriage. A marriage license that is signed by the official who performed the marriage ceremony, but does not have the date the marriage was recorded with the county clerk, is not acceptable. Ceremonial or church certificates or certificates that are issued by a justice of the peace are not acceptable.
- Your name and the name of your spouse on the marriage certificate must match your name and your spouse's name as they appear on the Board's/CPS's records. Any name change must be documented by court-issued change documents.
- A person you are divorced from is not eligible for coverage. If you provide a county-certified copy of your marriage certificate, you are certifying that you are currently married to the individual named on the certificate. If you provide a marriage certificate to establish the eligibility of a person you are divorced from or you fail to notify the Health and Benefits Team of a divorce from a formerly eligible spouse, you are committing fraud. You will be held responsible for any claims or premiums paid on behalf of an ineligible person.

Children
Documentation Required: Birth Certificate

To enroll a dependent child, submit a county-certified copy of the child's birth certificate; you also must establish your relationship to the child's other parent (or in the case of a stepchild, your spouse's relationship). Keep in mind the following:

- A county-certified copy of a birth certificate is issued by a municipality, county or state. The certificate must contain parental information and the birth registration number. Your name must appear on the birth certificate.
- If the child is your stepchild, your spouse's name must appear on the birth certificate.
- If you are the child's legal guardian, you or your spouse must not be named as one of the two parents.
- If the child is your adopted child and the birth certificate has not yet been amended to name you as a parent of the child, the letter issued by the governmental agency placing the child in your home will be accepted as documentation until the amended birth certificate can be issued.

If the dependent is your stepchild and you are divorced from the other parent, you must provide a copy of the divorce decree that is certified by the clerk of the court in which the divorce was filed. The divorce decree must name you only, or both you and your former spouse, as responsible for providing the child's health insurance in order for the child to be covered under the plan. If the divorce decree does not state who is responsible for providing health care coverage, and reserves the issue of child support, you must provide a copy of any later child support order. If there is no child support order, you must provide a notarized affidavit stating that although the issue of child support was reserved, no child support order has ever been entered in the court. If both the divorce decree and child support order do not say who is responsible for health insurance, the child can be covered under a Board plan if the other parent is not named as the person who can claim the child as a dependent on a federal income tax return. If the other parent is not named, you must provide a notarized statement that the child is claimed as your dependent for federal income tax purposes.

If your divorce decree states that your ex-spouse is responsible for providing your child's (or children's) health insurance, you cannot provide coverage under the Board health care plans unless you have the decree amended to name you as the responsible party, either solely or jointly with your ex-spouse. You must return to the court where your divorce was granted to have it amended. You will receive a Notice of Motion indicating your new court date. Submit a copy of it to the Health and Benefits Team. When the amendment has been ordered by the court, provide the Health and Benefits Team with a certified copy to complete your file.

If the dependent is your stepchild, your spouse must submit a copy of the original certified birth certificate that verifies the dependent's parent is your spouse. Your spouse's name must be on the child's birth certificate.

If you are the child's parent, but are not named as the parent on the birth certificate, the child cannot be covered as a dependent under a Board plan without a certified copy of the child support order requiring the child to be placed on your health insurance or an amended birth certificate naming you as the child's parent.

Unmarried dependent military veteran children who reside in Illinois, between the ages of 26 and 30, can be covered as dependents if they otherwise meet the criteria of dependency established for children under the age of 26. Birth certificates and proof of parental relationship must be established in the same manner as outlined on the previous pages. To be eligible, a veteran must:

- Have served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
- Have received a release or discharge other than a dishonorable discharge; and
- Submit proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." To obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans Affairs at (800) 437-9824 or the U.S. Department of Veterans Affairs at (800) 827-1000.
- The cost to continue the military dependent's coverage on the group plan is 100% of the cost of coverage (member portion plus the state/employer contribution), regardless of the number of dependents enrolled on the member's coverage. The Illinois mandate validating the cost can be found here https://www2.illinois.gov/cms/benefits/StateEmployee/Pages/State-Dependent-Enrollment.aspx.

Any children with disabilities who depend on you for support or maintenance because of their physical or mental handicap will be covered, if you provide proof of incapacitation, along with the birth certificate and proof of parental relationship, prior to the child's 26th birthday. You can request forms from the Health and Benefits Team. The determination of incapacitation will be made by either the Health and Benefits Team or a medical review firm. New hires and employees electing coverage due to a family status change may add disabled dependents age 26 and older when electing coverage for the first time, and the age limit for submitting documentation does not apply. However, the employee must provide proof that the child was disabled prior to the child's 26th birthday and that the child was continuously covered by group health coverage since the child's 26th birthday.

Domestic Partner
Affidavit of Domestic Partnership

A domestic partner is eligible for coverage as of the same date that your coverage becomes effective if you are a new employee. An eligible domestic partner can be either same or opposite sex. If you are an employee with existing coverage who is adding a domestic partner, the partner's coverage becomes effective as of the date that domestic partner status is established, provided that you submit the required documents to the Health and Benefits Department promptly. In the event that your domestic partner is confined to a hospital with an illness or injury, coverage will begin when your domestic partner is no longer confined.

Eligibility Requirements

The following eligibility requirements must be met for a domestic partner to be covered:

- You, the employee, must be enrolled in a Board-sponsored medical or dental plan; and
- You must submit a completed Affidavit of Domestic Partnership and meet the eligibility requirements for a Domestic Partner. Your affidavit needs to meet the minimum requirements listed below:
  a. You and your partner are at least 18 years of age and reside at the same residence;
  b. Neither you nor your partner is married (if you or your partner were previously married, proof of dissolution of marriage is required);
  c. You and your partner are not related by blood closer than would bar marriage in the State of Illinois;
  d. You and your partner are each other's sole domestic partner, responsible for each other's common welfare;
  e. You must submit certified birth certificates and copies of governmet-issued ID cards for both you and your partner.
- Acknowledgment of Imputed Income (AII) Form.

AND

At least two of the following four conditions must apply and proof must be submitted:

1. You and your partner have been residing together for at least twelve (12) months prior to filing the Affidavit of Domestic Partnership.
2. You and your partner have common or joint ownership of a residence.
3. You and your partner have at least two of the following arrangements:
   i. Joint ownership of a motor vehicle;
   ii. Joint credit account;
   iii. Joint checking account;
   iv. Lease for residence identifying both you and your partner as tenants.
4. You declare your partner as a primary beneficiary in your will.

The Health and Benefits Department will review your affidavit to determine whether you meet these requirements.

Coverage Termination for Domestic Partner

If the Health and Benefits Department approves your request, you must complete enrollment for your Partner within 31 days of the date your request for domestic partnership is approved. If you promptly submit all the required documentation, coverage will be effective as of the date your Partner is granted domestic partner status. If you do not enroll within 31 days, the next opportunity to do so is during the annual Open Enrollment.

The premium contribution deduction for your domestic partner is taken after-tax. The annual monetary value of the health benefit for your domestic partner will be reported as imputed income on your W-2. Please consult with your tax advisor about the tax consequences. All other eligibility and plan provisions apply.

If at any time your domestic partner becomes ineligible for benefits, it is your responsibility to notify the Health and Benefits Department in writing. Certain limitations exist in regard to continuing coverage for a domestic partner. Contact the Health and Benefits Department for more information. Following the termination of a domestic partnership, a minimum of 12 months must elapse before a new domestic partner may be designated.

Enrolling a Civil Union Partner

Civil Union Partner Certificate

Civil union partners may be added during Open Enrollment or as a "Family Status Change" at the time the civil union certificate is issued.

Civil Union Partner
Documentation Required: Civil Union Certificate

To add your civil union partner to health coverage you must submit the Civil Union Partner Information Form and an original certified civil union certificate and/or a birth certificate if you are adding a dependent of your civil union partner within 31 days of the date of your civil union.

The premium deduction for your civil union partner is taken after-tax. The annual monetary value of the health benefit for your civil union partner will be reported as imputed income on your W-2. Please consult with your tax advisor about the tax consequences. All other eligibility and plan provisions apply.

Coverage Termination for Civil Union Partner

If at any time your Partner becomes ineligible for benefits due to a termination of the partnership, it is your responsibility to notify the Health and Benefits Team in writing. Certain limitations exist in regard to continuing coverage for a civil union partner. To terminate the partnership submit the Original County Certified Dissolution of Civil Union certificate. Contact the Health and Benefits Team for details.

Name Changes

The names of both parents and the children's names must match on the birth certificates, the marriage certificate, divorce decrees, child support orders and notarized statements, if any, and on the records of the Board/CPS. If names do not match, certified court orders of name change must be provided to show the change in identity.

Acceptable Documentation

All documents must be certified as having been filed by the governmental unit that has jurisdiction over issuing such documents. Certified copies of documents generally have a raised or multi-colored seal, or are issued on multi-colored paper. Foreign documents must be issued by a governmental unit. If these documents are not in English, they must be accompanied by an English translation that is issued by a certified translator; prepared by the consulate of the foreign country that originally issued the document; or notarized by a notary who can read and write the language in which the document is prepared and swears that the translation is a faithful representation of the accompanying document.

Required Documents for Dependents: *A Summary*

To finalize your benefits choices, you must submit the required documentation within 31 days of the hire date or qualifying event date. Refer to the table below. See page 68 for instructions on submitting your documentation.

Benefit participant being added	Document(s) Needed
Spouse	An original certified marriage certificate.
Dependent (0-26 yrs.)	An original county certified Birth Certificate (with parental information)
Disabled dependent (0-26 yrs.)	Disabled dependent (0-26 yrs.)
Unmarried Military Dependent Children Who Are Residents of Illinois (ages 26 - 30) (Benefits terminate at the end of the month in which the 30th birthday occurs.)	An original certified birth certificate and military discharge paperwork (DD2-14).
Adopted children	If the child is your adopted child and the birth certificate has not yet been amended to name you and other adoptive parent as the child's parents, then the letter issued by the governmental agency placing the child in your home will suffice for documentation, until such reasonable time as the amended birth certificate can be issued.
Legal dependents (Court appointed)	You do not need to prove your relationship to the child's parents if you are the child's legal guardian. You must provide an original of the guardianship appointment certified by the clerk of the court in which the appointment occurred.
Civil union partner	An original certified civil union certificate. Acknowledgment of Imputed Income (AII) form.
Domestic partner	The following eligibility requirements must be met for a domestic partner to be covered: • You, the employee, must be enrolled in a Board-sponsored medical or dental plan; and • You must submit a completed Affidavit of Domestic Partnership and meet the eligibility requirements for a samesex Domestic Partner. Your affidavit needs to meet the minimum requirements listed below: a. You and your partner are at least 18 years of age and reside at the same residence; b. Neither you nor your partner is married (if you or your partner were previously married, proof of dissolution of marriage is required); c. You and your partner are not related by blood closer than would bar marriage in the State of Illinois; d. You and your partner are each other's sole domestic partner, responsible for each other's common welfare; e. You must submit certified birth certificates and copies of government-issued ID cards for both you and your partner. • Acknowledgment of Imputed Income (AII) Form. **AND** At least two of the following four conditions must apply and proof must be submitted: 1. You and your partner have been residing together for at least twelve (12) months prior to filing the Affidavit of Domestic Partnership. 2. You and your partner have common or joint ownership of a residence. 3. You and your partner have at least two of the following arrangements: i. Joint ownership of a motor vehicle; ii. Joint credit account; iii. Joint checking account; iv. Lease for residence identifying both you and your partner as tenants. 4. You declare your partner as a primary beneficiary in your will. The Health and Benefits Department will review your affidavit to determine whether you meet these requirements.

Wellness Program

Well onTarget®

BlueCross BlueShield of Illinois (BCBSIL) will administer the wellness program. As the sole medical carrier, BCBSIL will provide CPS employees with a fully integrated experience that can be customized to meet individual wellness goals.

The program is called Well onTarget and it is designed to give you the support you need to make healthy choices. With Well onTarget, you gain access to a convenient, secure website with personalized tools and resources, right at your fingertips.

To access Well onTarget, log in to Blue Access for Members (BAM) at BCBSIL.com. Once you are logged in to BAM, simply click the link on the right side of the page and it will take you to the Well onTarget portal.

Employees will no longer be penalized for not completing required wellness activities, but participation is highly encouraged. Take stock of yourself and your health. This program will help you do that.

Well onTarget Member Wellness Portal
At the heart of Well onTarget is the member portal. It links you to a suite of innovative programs, including:

onmytime Self-directed Courses
Reach your health goals at your own pace with online, self-directed courses for topics such as stress management and weight management.

Health and Wellness Content
The health library teaches and empowers through evidence-based, interesting articles.

Tools and Tracker
Use these interactive tools to help keep you on track for your next 5K or to monitor your blood pressure levels.

Fitness Program and Health Clubs
A flexible membership program gives you unlimited access to a nationwide network of gyms. Membership is month-to-month and there is no long-term contract required. Fees are $25 per month per member with a one-time enrollment fee of $25.

Blue Points
Earn Blue Points by completing activities such as tracking your calories or connecting a fitness tracking device. Blue Points can be redeemed for items such as gift cards or electronics.

Medical Plans At a Glance

You can select a PPO or HMO from a single carrier – **BlueCross BlueShield of Illinois.** We offer plans that are employee only, employee + one, or family coverage. CPS shares in the cost of coverage for this benefit.

BlueCross BlueShield BlueAdvantage HMO	BlueCross BlueShield PPO	BlueCross BlueShield PPO with HSA

HMO and PPO Plans Key Differences

HMOs	PPOs
Lower premiums	Slightly higher premiums
No deductibles	Carry over deductible credit provision only when the deductible is met during the last two months of the calendar year.
Doctor must be selected from pre-approved list of doctors.	Covers in-network and out-of-network doctors. Offers financial incentives for selecting doctors from the pre-approved list.
BlueCross BlueShield HMO requires referral from your primary care doctor to see a specialist doctor. Your primary care physician and their staff will manage and coordinate your care.	See a specialist doctor without referral. Pre-approval, however, is required for certain services such as MRIs and CT scans. (See page 23 for more information about pre-approval requirements.) BCBSIL nurses may reach out to you via a phone call to help coordinate or manage your care or your medical condition. This is an additional resource to answer your questions, help you effectively communicate with your doctor, and help you understand your benefits. Telemedicine (Virtual Visits) are available only for PPO and PPO with HSA plans. Employees and dependents will not incur out-of-pocket expenses when receiving physical and occupational therapy at an Athletico clinic. Deductibles and visit limits still apply.

Deductions are based on the paycheck date in accordance with the annual payroll calendar.

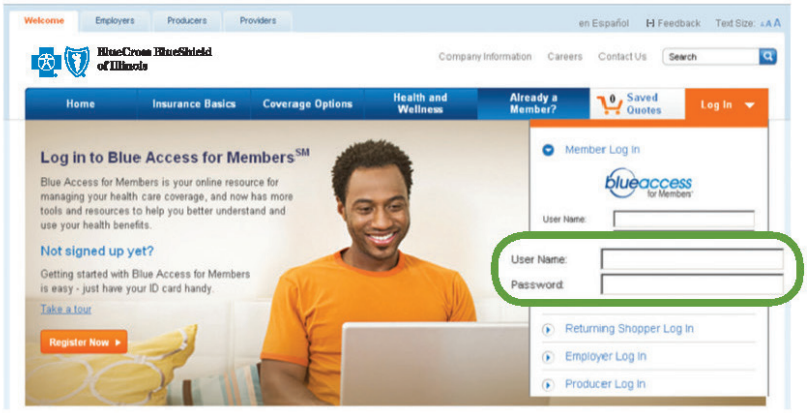
BlueAccess for Members

Want to find more information on your plan?

Log in to BAM, BlueAccess for Members, the BlueCross BlueShield member website to find information about your claims, request an ID card, and access their library of information. Visit **bcbsil.com/members.**

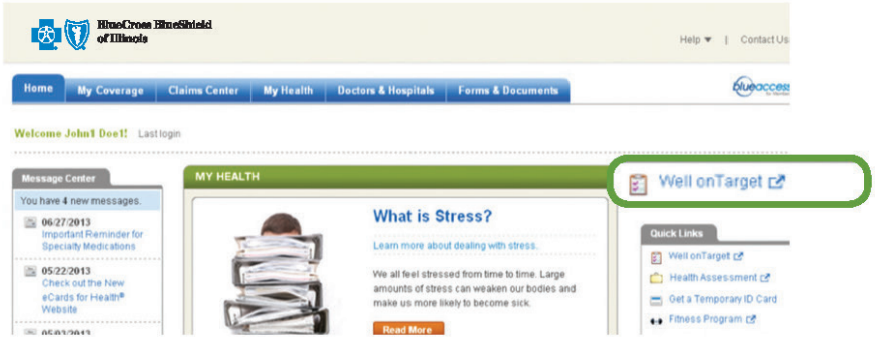
Log in or create an account here

Just log in to Blue Access for Members at bcbsil.com/members. If this is your first time logging in, you will need to register your account.



Click on the Well onTarget link to access the portal

Once you are logged in to Blue Access for Members, simply click the link on the right side of the page and it will take you to the Well onTarget portal, where you will find personalized tools and resources to help you plan your health and wellness path.



BlueCross BlueShield of Illinois BlueAdvantage Health Maintenance Organization (HMO)

Benefit Highlights for eligible expenses	BlueCross BlueShield BlueAdvantage HMO
Annual deductible	N/A
Out-of-pocket maximum	Single $1,500 Employee+1 $3,000 Family $3,000
Care in doctor's office	
• General office visits (e.g., x-rays, allergy shots, chemotherapy)	100% $30 Regular co-pay $45 Specialist co-pay $30 Urgent co-pay
• Wellness/preventive care (e.g., physical check-ups for adults and children, well baby care, colonoscopies, mammograms, pap smears and immunizations)	100% (no co-pay)
Inpatient hospital services	
• Hospital (semi-private) room and board	100% after $275 co-pay per admission
• Doctor's visits (including specialists), x-rays, drugs, surgeon fees and anesthesiologists	100%, $0 (co-pay)
Outpatient hospital care (including surgery)	Covered in full after $225 co-pay per visit
Maternity	
• $30 copay applies for 1st prenatal visit only	
• Prenatal/postnatal	100% after $45 co-pay
• Hospital coverage (mother and newborn)	100% after $275 co-pay
Covered emergency care	
• Emergency care (if deemed an emergency)	100% after $200 co-pay per visit for In-network and Out of network providers
• Ambulance	100% with $0 co-pay. Ground Transportation only.
Behavioral/Mental Health (unlimited visits)	
• Inpatient	100% after $275 co-pay
• Outpatient	100% after $20 co-pay
Therapy	
• Physical, occupational and speech therapy for restoration of function approved by doctor	100% for the number of visits which, if approved by a doctor, up to 60 visits combined for all therapies, plus $30 co-pay per visit per calendar year
• Chiropractic care	100% after $45 co-pay per visit up to 30 visits per calendar year
Care in skilled nursing facility	100%; 60 calendar day limit
Coordinated Home Care	100% (no co-pay)
Prosthetic devices and medical equipment	100%
Eligible full-time union employees	Eligible Full - time union employee Employee Only: 2.0% Employee + 1: 2.2% Family: 2.5%
Eligible Half-time Teachers	Employee Only: 4.0% Employee + 1: 4.4% Family: 5.0%
Eligible Non-Union Employees	Employee Only: 3.5% Employee +1: 3.7% Family: 5.0%

BlueCross BlueShield of Illinois Preferred Provider Organization (PPO)

Benefit highlights for eligible expenses	BlueCross BlueShield PPO	
	In Network	**Out of Network**
Annual deductible	Single $600 Employee+1 $1,800 Family $1,800	Single $1,200 Employee+1 $3,600 Family $3,600
Out-of-pocket maximum	Single $2,700 Employee+1 $5,200 Family $5,200	Single $5,400 Employee+1 $10,800 Family $10,800
Care in doctor's office		
• General office visits (e.g., x-rays, allergy shots and chemotherapy)	80% $25 Regular co-pay $40 Specialist co-pay $25 Urgent co-pay	50% $25 Regular co-pay $40 Specialist co-pay $25 Urgent co-pay
• Wellness/preventive care (e.g., routine physical check-ups for adults and children, well baby care, colonoscopies, mammograms, pap smears and immunizations)	100% (no co-pay)	100% (no co-pay)
Pre-authorization requirements • Procedure, therapy and surgical (See page 24 for more information.)	Pre-authorization required, failure can result in 50% additional co-insurance charge up to $1,000 plus the co-insurance that is applicable to the service. Benefits can be further reduced or denied completely if it is determined that treatment or admission is not medically necessary.	Pre-authorization required, failure can result in 50% additional co-insurance charge up to $1,000 plus the co-insurance that is applicable to the service. Benefits can be further reduced or denied completely if it is determined that treatment or admission is not medically necessary.
Telemedicine (Virtual Visits)	$25 co-pay	N/A
In-patient hospital services		
• Hospital (semi-private room and board)	$100 deductible per admission and 80% after deductible	$100 deductible per admission and 50% after deductible
• Doctor's visits (including specialists), x-rays, drugs, surgeon fees and anesthesiologists	Included in inpatient hospitalization	Included in inpatient hospitalization
Outpatient hospital care (including surgery)	80% after deductible	50% after deductible
Maternity		
• Prenatal/postnatal	100% after $40 co-pay	50% after deductible
• Hospital coverage (mother and newborn)	80% after deductible	50% after deductible
Covered emergency care		
• Emergency care (if deemed an emergency)	100% after $200 co-pay	100% after $200 co-pay
• Ambulance	100% after deductible	100% after deductible
Behavioral/Mental Health (unlimited visits)		
• Inpatient	80% after deductible	50% after deductible
• Outpatient	100% after $25 co-pay	80% after $25 co-pay
Therapy		
• Physical, occupational and speech therapy for restoration of function approved by doctor – up to 60 combined visits per calendar year	100% after deductible, then $30 co-pay	80% after deductible
• Chiropractic care up to 30 visits per calendar year	100% after deductible and $30 co-pay	80% after deductible
Care in skilled nursing facility (up to 120 days/year if medically necessary)	80% after deductible	50% after deductible
Prosthetic devices and medical equipment	80% after deductible	50% after deductible
Eligible full-time union employees	Employee Only: 2.2%	Employee + 1: 2.5% / Family: 2.8%
Eligible half-time teachers	Employee Only: 4.4%	Employee + 1: 5.0% / Family: 5.6%
Eligibile non-union employees	Employee Only: 3.7%	Employee +1: 4.0% / Family: 5.0%

BlueCross BlueShield of Illinois PPO with Health Savings Account (HSA)

In addition to HMO and PPO plans, CPS offers a PPO with Health SavingsAccount (HSA) plan. An HSA is a tax-favored account used in conjunction with an HSA-compatible health plan. The funds in the account are used to pay for IRS-qualified medical expenses such as services applied to the deductible, dental, vision and more.

CPS will contribute up to $600 for single coverage, $1,500 for employee +1 or $2,000 for family coverage to your individual HSA. Funds will be paid incrementally per pay period. Employer contributionswill be pro-rated based on the beginning date of enrollment with the PPO with HSA plan.

Employer and employee contributions will be deposited to the participant's accounts after each pay date in one lump sum.

- A CPS employer contribution (seed money) you can apply toward your deductible and other medical expenses.
- Funds roll over year to year and are yours even if you leave CPS.
- Monthly premiums are lower and tax savings are higher.

Per IRS regulations, employees cannot be enrolled in both the HSA plan and the Health Care FSA plans concurrently. It is against current IRS regulations to be covered under the PPO with HSA and contribute to the Health Care FSA plan. More information can be found in IRS Publication 969.

Per IRS, 2022 employee + employer contribution maximums are:

- Employee Only Coverage: $3,650
- Employee+1 and Family Coverage: $7,300

HSA funds roll over year-to-year; there are tax benefits on contributions, earnings and distributions; and long-term investment opportunities are available.

Per IRS, 2022 catch up for age 55 and up is $1,000

The HSA is the employee's account, not CPS'. All transactions are handled between the employee and HSA Bank. It is the employee's responsibility to complete the process to open their account within 60 days. If your account is not opened, contributions cannot be deposited.

Monthly maintenance fees may be charged depending on the balance in the account. Contact HSA Bank for more information on monthly fees.

Use the savings from the lower premium to put into your HSA account and watch your savings build up faster!

Your contribution amount will be divided among the pay periods in the year. If you do not receive a paycheck during the summer, for example, a makeup contribution for the missed pay periods during the summer months will be deposited into your HSA Bank account for the employer portion at the beginning of the new school year.

BlueCross BlueShield of Illinois Health Savings Account (HSA)

Benefit highlights for eligible expenses	In Network	Out Of Network
CPS employer contribution*	Single $600 Employee+1 $1,500 Family $2,000	
Annual deductible	Single $2,000 Employee+1 $4,000 Family $4,000	Single $4,000 Employee+1 $8,000 Family $8,000
Out-of-pocket maximum (established by IRS regulations)	Single $4,000 Employee+1 $8,000 Family $8,000	Single $8,000 Employee+1 $16,000 Family $16,000
Care in doctor's office		
• General office visits (e.g., x-rays, allergy shots, and chemotherapy)	80% after deductible	50% after deductible
• Wellness/preventive care (e.g., routine physical check-ups, well baby care, colonoscopies, mammograms, pap smears, and immunizations)	100% (no co-pay, no deductible)	100% (no co-pay, no deductible)
Pre-authorization requirements • Procedure, therapy and surgical. (See page 24 for more information.)	Pre-authorization required, failure can result in 50% additional co-insurance charge up to $1,000 plus the co-insurance that is applicable to the service. Benefits can be further reduced or denied completely if it is determined that treatment or admission is not medically necessary.	Pre-authorization required, failure can result in 50% additional co-insurance charge up to $1,000 plus the co-insurance that is applicable to the service. Benefits can be further reduced or denied completely if it is determined that treatment or admission is not medically necessary.
Telemedicine (Virtual Visits)	80% after deductible	N/A
Inpatient hospital services		
• Hospital (semi-private) room and board	80% after deductible	50% after deductible
• Doctor's visits (including specialists), x-rays, drugs, surgeon fees and anesthesiologists	Included in inpatient hospitalization	Included in inpatient hospitalization
Outpatient hospital care (including surgery)	80% after deductible	50% after deductible
Maternity		
• Prenatal/postnatal	80% after deductible	50% after deductible
• Hospital coverage (mother and newborn)	80% after deductible	50% after deductible
Covered emergency care		
• Emergency care (if deemed an emergency)	80% after deductible	80% after deductible
• Ambulance	100% after deductible	100% after deductible
Behaviorial/Mental Health (unlimited visits)		
• Inpatient	100% after deductible	80% after deductible
• Outpatient	100% after deductible	80% after deductible
Therapy		
• Physical, occupational and speech therapy for restoration of function approved by doctor • Limited to 60 combined visits per calendar year	100% after deductible, then $30 co-pay	80% after deductible
• Chiropractic care • Limited to 30 visits per calendar year	100% after deductible, then $30 co-pay	80% after deductible, then $30 co-pay
Care in skilled nursing facility (up to 120 days/year if medically necessary)	80% after deductible	50% after deductible
Prosthetic devices and medical equipment	80% after deductible	50% after deductible
Pharmacy	80% after deductible	50% after deductible
Eligible full-time union employees	Employee Only: 0.0% Employee + 1: 1.0%	Family: 1.9%
Eligible half-time teachers	Employee Only: 0.0% Employee + 1: 2.0%	Family: 3.8%
Eligible non-union employees	Employee Only: 2.8% Employee +1: 3.0%	Family: 3.8%

*** Health Savings Account (employer contributes this amount to the employee)**

Funds will be deposited in the accounts on each pay period and will be calculated incrementally based on pay period.

Clinical and Pre-Authorization for PPO and PPO with HSA Plans

BlueCross BlueShield of Illinois manages the pre-authorization process for CPS employees and dependents enrolled in the PPO and PPO with HSA health plans. Pre-authorization is designed to ensure you receive quality medical care while discouraging unnecessary treatment. To verify that certain treatments and hospital stays are appropriate, you must obtain approval from the medical professionals at BCBSIL. They are available from 8 a.m – 6 p.m. Monday through Friday at (800) 572-3089 for Pre-authorization for medical and for behavioral health services.

Pre-Authorization Requirements

Pre-authorization is required for the following services and procedures:

- Inpatient hospital care, including acute rehabilitation hospitals and surgeries.
- Inpatient skilled nursing facility care.
- Organ transplants.
- Air ambulance transportation.
- Certain outpatient surgeries and procedures such as:
  - Blepharoplasty (surgery to eyelids)
  - Breast surgeries (reduction, reconstruction except when related to mastectomy, biopsy and lesions)
  - CAT scans
  - MRI
  - Nasal surgery (rhinoplasty and septoplasty)
  - PET scans
  - Sclerotherapy and ligation, vein-stripping
  - Sleep studies
- Hospice: inpatient and home.
- Home nursing visits.
- Private duty nursing.

Pre-Authorization Requirements	• Durable medical equipment and supplies such as:
	  ◦ Hospital beds
	  ◦ Ventilators
	  ◦ Prosthetics
	• Other durable medical equipment that costs $1,000 or more.
	• Enteral formula (life-sustaining tubal feeding).
	• All pregnancy care (during the first three months or as soon as the pregnancy is confirmed and within two business days after admission for delivery, not including weekends).

Coordination with Medicare	If you remain an employee after you reach age 65 and become eligible for Medicare, the Board-sponsored plan will be the primary plan and Medicare will be secondary. This plan will also be primary for your spouse, if he or she is age 65 or older, eligible for Medicare and is covered by a Board-sponsored plan.

	In cases of End Stage Renal Disease (ESRD), the Board-sponsored plan is primary for the first 30 months. It is important that you inform the Claims Administrator if you have ESRD.
When to Call	You must call at least seven (7) days in advance for most services requiring pre-authorization. You must call within two (2) business days after emergency treatment or inpatient admissions. All pregnancies must be pre-authorized twice, during the first three (3) months or when the pregnancy is confirmed (if later) and again within two (2) business days after admission for delivery (not including weekends).
What If I Don't Call?	If you do not call for pre-authorization and/or follow the program's recommendations, you will be responsible for 50% of eligible charges (capped at $1,000 per individual per event per hospital stay). You will pay this penalty plus the co-insurance that applies. Also, benefits could be further reduced if it is determined that the treatment or admission is not medically necessary.
Example 1 MRI	LaTanya, a 32-year-old longtime runner, is experiencing severe back pain during her workouts. LaTanya's doctor has diagnosed her with back problems and has ordered an MRI. LaTanya, her doctor, a family member or a friend must notify BCBSIL and receive approval prior to her receiving an MRI.
Example 2 Outpatient Procedures	Caleb, age 7, has had numerous bouts of a sore throat and neck swelling over the past couple of years. During a recent examination, Caleb's doctor found a lump in Caleb's neck. The lump was not viewable with a normal X-ray so his doctor has suggested that Caleb have an MRI. Because Caleb is a minor, his doctor, the facility or a family member (parent or legal guardian) must notify BCBSIL prior to the scheduled date of this outpatient procedure.
Example 3 Inpatient surgery and hospital admission	Maria, age 55, who has severe osteoarthritis, is scheduled to have a knee replacement. This surgery will require Maria to be in the hospital for several days. Maria, her doctor, the facility, a family member or friend must notify BCBSIL as soon as the admission date is scheduled to pre-authorize this inpatient surgery and hospital admission.

Prescriptions

We wanted to make it easy, so we offer three convenient ways for CPS employees to purchase prescription drugs. The program covers eligible drugs purchased:

At a participating pharmacy	By mail-order	At a non-participating pharmacy

Specialty Drugs

CVS/Caremark pharmacy staff continually reviews medicines, products and prices for your plan sponsor. This is done to make sure that medicines that work well and are cost-effective to become part of your benefit plan. As part of this effort, there are changes to your drug benefit plan that could affect certain specialty prescription drugs. Call CVS Caremark Specialty Pharmacy toll-free at (800) 237-2767 if you have questions.

Prescription Drug Program Details	When to use which benefit Where	Retail Program	Mail Service Program
		For immediate or short-term medicine needs up to a 30-day supply You can use your prescription benefit at more than 62,000 Caremark participating retail pharmacies nationwide, including Target and over 20,000 independent community pharmacies. You can fill 90 days of medicine at a retail CVS or Target store. To locate a Caremark participating retail pharmacy in your area, login to your account at www.caremark.com and select the 'Find a Pharmacy' link under the 'My Prescriptions' tab, or call CVS Customer Care toll-free at (866) 409-8523.	For maintenance or long-term medicine needs up to a 90-day supply Simply mail your original prescription along with the mail service order form to CVS. Your medicines will be sent directly to your home. Standard delivery is free of charge for mail orders.
Cost to you HMO and PPO		$10 for each generic medicine after deductible. $40 for each brand-name medicine on the drug list after deductible. $55 for each brand-name medicine not on the drug list after deductible. $95 for specialty medicine after deductible.	$20 for each generic medicine after deductible. $90 for each brand-name medicine on the drug list after deductible. $120 for each brand-name medicine not on the drug list after deductible. $200 for specialty medicine after deductible.
Cost to you PPO with HSA		80% covered after medical deductible is satisfied.	80% covered after medical deductible is satisfied.

Important Change to Prescription Drug Deductible

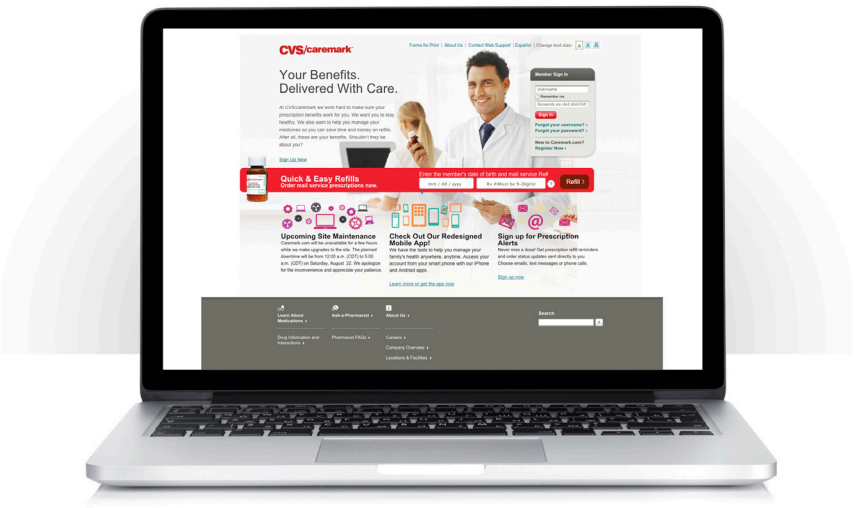
All CPS employees enrolled in the BlueAdvantage HMO or PPO plan will have to pay a $75 prescription drug deductible per calendar year per household. Employees who are enrolled in the HSA plan must satisfy the medical deductible before prescription coinsurance applies.

Important Change About Generic vs Brand Name Prescriptions

All CPS employees enrolled in a medical plan will only have access to generic drugs. Brand name drugs will only be covered if approved by Caremark Doctors through an appeal process or the employee's doctor completes the Caremark prior authorization process.

Web Services

Register at www.caremark.com to find a local pharmacy and to access tools that can help you save money and manage your prescription benefit. To register, have your benefits ID card handy.



Non-Participating Pharmacy Purchases

In most cases, you will not need to visit a non-participating pharmacy, because the Caremark Retail Program includes more than 62,000 participating pharmacies. However, if you choose a non-participating pharmacy, you will pay 100% of the prescription price. You will then need to submit a paper claim form, along with the original prescription receipt(s), to Caremark for reimbursement of covered expenses. Covered prescriptions purchased at a non-participating pharmacy will be reimbursed at 60% of the generic drug cost. The plan will also only pay 60% of the generic drug cost if a brand-name drug is issued when a generic drug is available. Submit paper claim forms to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Drugs that Qualify for Coverage	• Federal legend drugs (drugs requiring a prescription). • Compound prescriptions (limits and exclusions apply). • Insulin. • Women's contraceptives (limits and exclusions apply). • Men's Erectile Dysfunction medications (limits and exclusions apply) • Specific supplements (i.e., folic acid, iron and fluoride). • Low-dosage aspirin. • Tobacco cessation (generic only). • Infertility medications. • Disposable insulin syringes/needles and diabetic supplies. • Acne medication (with prior certification from Caremark for participants over age 35). • Growth hormones (with prior certification from Caremark).
Drugs that are Not Covered	• Cosmetic drugs such as Rogaine. • Drugs available without a prescription, except insulin. • Prescription drugs with an over-the-counter equivalent. • Drugs for the treatment of obesity, morbid obesity, or weight-loss. • Appetite suppressants. • Brand contraceptives (oral and injection) and contraceptive devices that have a generic equivalent. • Medical supplies and equipment. • Drugs not prescribed by a provider acting within the scope of his or her license. • Experimental, investigational or unproven drugs or therapies. • Drugs provided to you by the local, state or federal government and any drug for which payment or benefits are provided by the local, state or federal government (for example, Medicare). • Prescription vitamins. • Topical nail-fungal medication (for oral, limits and exclusions apply). • Replacement prescription drugs resulting from loss or theft.

Dental Plan Options

Delta Dental DHMO

Dental care coverage is provided at no cost to you; CPS covers the full dental contribution deduction for all coverage levels. And, you get to choose your own dentist. Just use a facility ID from the provider network sponsored by Delta Dental, which can be found at www.deltadentalil.com. (Note: Select the DELTACARE Network when searching for an in-network dentist on Delta Dental's website.)

Delta Dental PPO

If you choose the PPO, CPS will cover the cost of the employee-only contribution. Employees pay an additional cost for +1 or family coverage. Under the PPO plan, you can select either an in-network or an out-of-network provider. The plan will pay a certain percentage of the PPO rate whether or not you use a network provider.

Services	Delta Dental HMO	Delta Dental PPO	
		In Network	Out of Network
Preventive	100%	80% of PPO rate	80% of PPO rate
Basic	75–85%	80% of PPO rate	80% of PPO rate
Major	65–70%	50% of PPO rate	50% of PPO rate
Individual maximums			
Deductible	None	None	$100 annually
Benefit Limit	None	$1,500 annually	
Employee Contributions – 26 Pay Periods			
Employee only	None	None	
Employee +1	None	$9.71 per pay period	
Family	None	$20.56 per pay period	
Employee Contributions – 20 Pay Periods			
Employee only	None	None	
Employee +1	None	$12.62 per pay period	
Family	None	$26.73 per pay period	

Vision Plan Options

Basic Vision

Employees and eligible dependents enrolled in BCBSIL medical plans can access basic vision coverage through EyeMed Vision Care at no cost to you. The basic vision plan provides you one eye exam per year for a $15 co-pay. In addition, you will receive discounts on eyewear.

Enhanced Vision

For a monthly premium, you can upgrade to the Enhanced Vision plan, which includes coverage for glasses and contacts, and discounts on laser vision correction. Choose from independent doctors and retail providers to find the one that best fits your needs and schedule.

If you decide to upgrade to the Enhanced Vision Plan for a monthly premium, you will receive coverage for glasses and contacts, and discounts on laser vision correction. Reimbursement is available for out-of-network benefits, but the greatest savings are with in-network providers. See details in the certificate of coverage.

Digital Retinal Exam covered in full w/ $0 co-pay once every calendar year

Standard lenses once every calendar year
- Cost: Single, bifocal, trifocal and lenticular: $25 co-pay.
- Lens Options: UV treatment $10, tint (solid and gradient) $10, standard plastic scratch coating $0, standard polycarbonate (adults) $35, standard polycarbonate (kids under 19) $0, standard anti-reflective coating $45, polarized 20% off retail.

Frames once every calendar year
- Any available frame at provider location – $0 copay, $150 allowance, 20% off balance over $150

Contact lenses once every calendar year
- Conventional – $0 co-pay, $175 allowance, 15% off balance over $175
- Disposable – $0 co-pay, $175 allowance, plus balance over $175

Exam options
- Standard contact lens fit and follow-up – up to $55
- Premium contact lens fit and follow-up – 10% off retail price

Additional discounts and features
- Receive a 40% discount off complete pair eyeglass purchase
- 20% discount on non-prescription sunglasses
- 20% discount on other lens options and services
- 15% discount on conventional contact lenses once the funded benefit has been used.
- 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

Deductions Per Paycheck

20 Pay Periods
- Employee Only – $4.44
- Employee + 1 Dependent – $6.48
- Family – $11.63

26 Pay Periods
- Employee Only – $3.42
- Employee + 1 Dependent – $4.99
- Family – $8.95

Freedom Pass
- CPS employees and dependents enrolled in the Enhanced Vision Plan can get any pair of frames for free at Target Optical stores. To redeem your frames, you must log into EyeMed.com and print off the “Freedom Pass” from the special offers page and present it at the store.

Behavioral Health, Addiction, and Employee Assistance Program

Behavioral Health

The help you need to manage life's demands and addiction

We're not here to judge; we're here to help, maintaining the strictest confidence. As a CPS employee, you can access counseling and substance abuse recovery services to help you effectively deal with stressful and challenging situations, and feelings such as:

Sadness	Stress
Alcohol abuse	Anger management
Drug abuse	Relationship problems
Grief	Domestic abuse
Problems with food	Work issues
Gambling problems	

If you are enrolled in the PPO or PPO with HSA, contact BCBSIL at (800) 851-7498 to access services. If you are in the BlueAdvantage HMO plan, contact your primary care physician to receive services.

Employee Assistance Program (EAP)

CPS offers an Employee Assistance Program (EAP) that can help you and your household members with a wide range of issues affecting your overall quality of life. Offered through Magellan Healthcare, all employees are automatically enrolled in the EAP, which is provided in strict confidence and at no cost to you. The benefit includes up to 5 confidential counseling sessions with a licensed behavioral health professional, as well as comprehensive online information and resources. The program can assist with everything from job stress, family or relationship concerns, depression or anxiety, substance abuse or misuse, legal and financial issues and more. You may reach the EAP by phone, 24/7/365 for a consultation, or to link to a counselor or crisis intervention at (800) 424-4776 (800-4CHIPSO) or online at **www.magellanascend.com**.

Short-Term Disability

CPS provides employer-paid Short-Term Disability benefits for all eligible employees. All CPS employees who are members of an eligible class are covered under short-term disability. The policy in full legal detail can be obtained on **CPS.edu/Staff then click on the link for HR4U.** Here are some highlights.

Summary

This benefit is designed to replace income lost during periods of disability resulting from a non-occupational injury, illness, or pregnancy. Employee contributions and enrollment forms are not required. All CPS employees who are members of an eligible class are covered under short-term disability.

Eligible Class is defined as:

1) Collectively Bargained Employees; or
2) Non-Union Employees (Employees who are not members of a bargaining class)
a) Who are full-time benefits eligible employees under Board rules or policies; **AND**
b) Who are part-time teachers assigned to a position number and benefits eligible employee as a member of the Chicago Teachers Union; and
c) Who are actively employed in their position with CPS

Effective Date of Coverage

Coverage begins on the first calendar day of the month following 60 consecutive days of employment. Employees who are rehired within 12 months from the date of the employment termination with CPS will be eligible for coverage as of the date of rehire as long as they worked 60 days in their prior employment with CPS. Employees suspended without pay are ineligible for Short-Term Disability.

Submitting a Request	If you meet the eligibility requirements and you have a medical condition that renders you unable to work, you should initiate your claim within 10 calendar days from your first date of absence due to your disability by going to HR4U > Self Service > Benefits > Leave Life Events or by calling (773) 553-4748. After you complete the Life Event you then have 15 days to submit your medical certification to the Absence and Disability Management Department. If you do not report your claim within 10 calendar days from your first date of absence, your disability claim may be denied. In addition to filing for Short-Term Disability, your application will be evaluated for a leave of absence under the Family Medical Leave Act (FMLA). An approved Short-Term Disability claim runs concurrently with FMLA if you are FMLA eligible. To be eligible for FMLA you must work for CPS for one (1) year and 1250 hours.
Ten Sick Day/Seven General Use Day Exhaustion Rule	For any Period of Disability, the Ten Sick Day/Seven General Use Days Exhaustion Rule requires, prior to the beginning of your Period of Disability, that you use ten sick days or seven general use days of your current year allotment.

Submitting a Request

1	2	3	4
Notify your supervisor prior to your leave of absence or within 10 days of your disability. Follow the required call off procedures established by your manager/principal.	Apply online: CPS.edu/Staff then click on the link for HR4U. Download required forms and submit within 15 calendar days.	Absence and Disability Department will review medical certification upon receipt and send a determination letter to you and your supervisor within 4 business days.	Ongoing communication with your supervisor and / or Absence and Disability Department may be required throughout the duration of your leave of absence.

Calendar Days 1 – 30

100% During the period beginning on the date of disability, and continuing up to and including the 30th day, the amount you receive will be 100 percent of the Daily Rate of Pay*, calculated by multiplying your hourly base pay x scheduled hours. You will receive this percentage of that.

Calendar Days 31 – 60

80% Beginning on the 31st calendar day from the date of disability and continuing up to and including the 60th day, you will receive 80 percent of the Daily Rate of Pay.

Calendar Days 61 – 90

60% From the 61st calendar day from the date of disability continuing up to and including the 90th day, the percentage shall be 60 percent of the Daily Rate of Pay.

- Paid CPS Holidays will be paid by CPS and are counted toward the 90 calendar day maximum benefit.
- Paid CPS Holidays will be paid at the rate of the disability period (100%, 80%, and 60%)
- Intersession pay will be based on the formula as agreed to by the collective bargaining agreement and are counted towards the 90 calendar day maximum benefit.
- Short-term disability benefits you receive from the Plan are taxable income.
- Federal and applicable state and local taxes are withheld from benefit payments.

***If you have a change in your base pay while on disability, your base pay used to calculate your short-term disability benefit will be adjusted based on the new salary rate.**

Supplemental Income with Usage of Sick Days

An employee may supplement the STD payment in days 31 – 90 to reach 100% income during such period(s) by usage of sick days from their sick day bank(s). Employee must complete the authorization form and elect the specific banks for deductions. Please note, usage of sick days is not an automatic process. Failure to complete the authorization form within the time period will result in no sick day usage during the eligible period(s), and no retroactive sick day usage will be applied to past claim period(s).

Payment of Daily Benefit

Daily Benefits shall be paid for each regular work day for which the employee would have been scheduled had the employee not been disabled, but only for days during the Period of disability and not in excess of the Maximum Benefit Period. Examples of days not paid by STD include: Holidays, Snow days, and Intercessions. Short-Term Disability benefits will not be paid during the summer intersession. If the employee remains disabled beginning with the first scheduled work date following the end of the summer intercession, the employee will be responsible for contacting the plan Absence and Disability Department to submit a new claim.

Benefits paid under the Plan are reduced by the total amount of certain other income for which you may be eligible during any period of disability. These sources of other income are:

- Any settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier which provides benefits that are intended to replace any portion of your pay
- Any amount of STD benefits paid for days determined later that benefits were not due. In the case that there are future benefits, overpayments will be deducted from benefits due.

Reduction of Benefit Payments

When claim benefits are payable: Benefits are paid biweekly, for the prior period for which you are owed, after CPS receives the required proof. If any amount is unpaid when disability ends, it will be paid when required proof of disability is in hand. Short-term disability benefit payments begin on the first day after you have exhausted ten sick days or seven general use days from your current fiscal year's allotment. You must be under the care of a physician who verifies, to the satisfaction of the Absence and Disability Department, that because of your disability you are unable to perform the essential duties of your employment with CPS.

Short-term disability benefit payments begin on the first day after you have exhausted ten sick days or seven general use days from your current fiscal year's allotment. You must be under the care of a physician who verifies, to the satisfaction of the Claims Administrator, that because of your disability you are unable to perform the essential duties of your employment with CPS.

Reduction of Benefit Payments (cont.)

Once you begin receiving short-term disability benefits, your benefits continue until the earliest of the following events occurs:

- You no longer have a covered disability under the Plan. Either you are able to resume the essential duties of your regular position or you take a position at CPS that accommodates your medical restrictions.
- You are unable to provide satisfactory medical evidence of a covered disability.
- You do not follow the treatment plan ordered by your physician.
- You fail to cooperate with a scheduled independent medical examination (IME) or functional capacity evaluation (FCE).
- You begin work similar to your work with CPS for wage or profit with another employer or through self-employment.
- You have received benefits for a 90-day period.
- You are incarcerated.
- Your employment ends for any reason, including retirement or death.
- The plan terminates.
- You become suspended from your employment at CPS.

Duration of Short-Term Disability and Successive Periods of Disability

Short-Term disability allows you to continue to receive a full or partial salary for up to 90 days in a rolling 12-month period. A rolling 12-month period is measured backward from the last date you used any Short-Term Disability. For example, if a requested Short-Term Disability was to begin on July 1, the 12 months preceding that date would be reviewed to determine whether any Short-Term Disability time had already been used. If so, that time would be deducted from the remaining amount of Short-Term Disability time available. An employee must be actively at work for 5 consecutive business days prior to being eligible for their new 90 days of benefits.

Documentation of Disability

You will be required to provide certain information to the Absence and Disability Department to have your request reviewed, including the following:

- A signed medical information authorization form.
- Medical documentation of objective findings to support your medical condition from your health care provider.

Objective findings of a disability are necessary to substantiate the period of time your physician indicates you are unable to work because of your disability. Objective findings are those your physician observes through objective means, not your description of the symptoms.
Objective findings include:

- Physical examination findings (functional impairments/capacity).
- Diagnostic test results/imaging studies.
- Diagnoses.
- X-ray results.
- Observation of anatomical, physiological or psychological abnormalities.
- Medications and/or treatment plan

Mental Health Conditions	Medical documentation for mental health conditions is required to be supplied by a Clinical Psychologist and/or a Psychiatrist. Initial diagnosis of postpartum depression can be accepted from a Doctor of Obstetrics and Gynecology. Ongoing treatment, however, must be provided by a Clinical Psychologist and/or a Psychiatrist.
Organ Donation	Medical documentation for organ donation is required to qualify for Short-Term Disability. Donor may qualify for Short-Term Disability with proper medical certification.
Physical Examination	The Absence and Disability Department also may require you to undergo an independent medical examination and/or a functional capacity test. If you do not cooperate with this request (for example, you fail to keep a scheduled appointment), your benefits may be terminated. If the Absence and Disability Department requests that you undergo an independent medical examination (IME) and/or a functional capacity evaluation (FCE), CPS will pay the fee. At our discretion, we may ask you to participate in rehabilitation services.
Short-Term Disability Coverage Exclusions	Benefits will not be paid for any part of a period of disability that results from the following: • A work-related injury for which you are receiving workers' compensation benefits. • Participation (or as a consequence of having participated) in the commission of a felony. • Any act of war declared or undeclared, service in the armed forces of any country, performing police duties as a member of any military organization. • A cosmetic procedure (however, disability benefits will be paid for reconstructive surgery following a mastectomy; for surgery the medical plan determines to be medically necessary; and for complications that prevent your return to work within the normal recovery period for a cosmetic surgery procedure).
A Denied Claim	In the event a claim for Short-Term Disability is denied, the Absence and Disability Department will send a letter with the following information: The specific reason(s) for the denial, including: • Specific reference to all pertinent provisions upon which the denial is based. • Appropriate information as to the steps to be taken if you wish to submit an appeal for review of the claim denial. • Claim Appeal Procedure Level 1. To appeal a denied Short-Term Disability claim, you must request the appeal in writing, no more than 30 days from the date of the denial. You are expected to return to work the next scheduled work day unless you are on an approved Family Medical Leave of Absence. You must follow the normal absence reporting procedures. No-call-no-show will result in disciplinary action. Failure to return to work may result in Absence Without an Approved Leave (AWOL) proceedings.

Requests for review of a denied claim should be sent to:

Attn: Absence and Disability Department
2651 W. Washington Blvd.
Chicago, Illinois 60612

When you request this review, you should state the reason(s) you believe the claim was improperly denied and submit for review any pertinent documents, including but not limited to additional medical or vocational information and any facts, data, questions or comments you deem appropriate so that the Absence and Disability Department may give your appeal proper consideration. The appeal review determination will be made by the Absence and Disability Department, ordinarily no later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing the appeal. If special circumstances require more time to consider an appeal, the Absence and Disability Department may take up to14 additional days to render a determination. If this additional time is needed, the Absence and Disability Department will notify you in writing by mail before the 45-day period has expired.

Claim Appeal Procedure - Final

If the Absence and Disability Department denies your Short-Term Disability claim for benefits on appeal, you have 14 days from the date of receipt of the written notification of denial to appeal to the Absence and Disability Department for a final determination. Requests for review of a final appeal should include the reason(s) as outlined in the previous paragraph and should be sent to the Absence and Disability Department at the above address or fax number (773) 553- FMLA (3652). The final appeal decision will be made by an appeal committee at CPS.

The final appeal review determination will be made by an appeal committee at CPS, ordinarily no later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing the appeal. If special circumstances require more time to consider an appeal, the Absence and Disability Department requires14 additional days to render a determination. If this additional time is needed, the Absence and Disability Department will notify you in writing by mail before the 30-day period has expired.

The decision made by the Absence and Disability Department for all Short-Term Disability appeals is final and binding.

Rights of Restitution and Reimbursement and Subrogation

If the Short-Term disability plan provides or pays benefits as a result of a disabling injury or sickness:

- Caused by the act or omission of another party;
- Covered by Workers' Compensation;
- For which no-fault or employers' liability laws also provide coverage;
- Sustained on the property of a third party that has premises liability insurance available, then:

Rights of Restitution and Reimbursement and Subrogation (cont.)

CPS, or a third party acting on behalf of CPS, has an equitable lien on any moneys that might be owed to you for the injury or sickness as well as the equitable right to recover the value of services and payments made under the Short-Term Disability plan. This right is by restitution and reimbursement or subrogation, and exists because the benefit payable under the Plan is the net amount of covered claims after taking all other forms of recovery into account.

The right of restitution and reimbursement means that the Short-Term Disability plan has a lien on any recovery that you become entitled to receive. Accordingly, if you receive benefits under any of the circumstances listed, you must repay the Short-Term Disability plan the amount of the benefits you receive from another source – up to the amount you have received from the Short-Term Disability plan – because the plan has an equitable lien in that amount. Recovery includes all amounts received by you from any persons, organizations or insurers by way of settlement, judgment, and award or otherwise on account of such injury or sickness. The right of subrogation means that CPS, or a third party acting on behalf of CPS, may make claim in your name or CPS's name against any persons, organizations or insurers on account of such injury or sickness.

The rights of restitution and reimbursement or subrogation apply whether or not you have been fully compensated for your losses or damages by any recovery of payments. If you settle a claim against a third party, you are deemed to have been made whole by such settlement so that CPS, or a third-party acting on behalf of CPS, is entitled to immediately collect the present value of its subrogation rights as the first priority claim from said settlement or judgment. CPS is entitled to the first dollars recovered. No attorney's fees may be payable from any subrogation recovery unless CPS has been notified of the attorney's proposed representation in advance, and unless CPS has agreed in writing to the representation of CPS's interests by that attorney.

Under certain circumstances, you will be required to hold CPS harmless against future benefit payments due to the injury or sickness for which a settlement is reached. These rights of restitution and reimbursement or subrogation apply to any type of recovery from any third party, including but not limited to recoveries from tort-feasors, underinsured motorist coverage, uninsured motorist coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. Any amounts you receive from such a recovery must be held in trust for CPS's benefit to the extent of the Short-Term Disability plan's restitution and reimbursement or subrogation claims. You must cooperate fully with every effort — by CPS, or other third party acting on behalf of CPS — to enforce CPS's rights of restitution and reimbursement or subrogation.

Access to Records

By filing a claim for benefits under the Short-Term Disability plan, you authorize CPS and its Absence and Disability Departments to have access to any health records or medical information held by any healthcare provider and employment information held by any employer. You also authorize the Absence and Disability Department to use your health records, medical information and employment information for claims processing (including, without limitation, claims for restitution and reimbursement or subrogation under the Short-Term Disability plan), disability claims data evaluation, and evaluation of potential or actual claims against the Absence and Disability Department.

CPS, on its own behalf or through a third party administrator, has the right to recover any benefit payments that are made in excess of the amount you are eligible to receive under the Plan, including but not limited to:

- Erroneous payments.
- Payments made for any periods for which you fail to provide satisfactory evidence of a covered disability.
- Payments not reduced by amounts you receive from a source listed under "Reduction of Benefit Payments."

Retroactive payments from any source listed under "Amount of the Benefit You Receive — Reduction of Benefit Payments" must be immediately disclosed to the Absence and Disability Department. Excess payments will be recovered directly from you, or if necessary, from future benefit payments or from your estate, to the extent permitted by law.

Long-Term Disability

In addition to the CPS-provided Short-Term Disability benefit, employees have the option of purchasing Voluntary Long-Term Disability Insurance. Long-Term Disability (LTD) Insurance is designed to continue part of your income if you have a medically certified disability. You have two plan options: a 90-day waiting period or a 180-day waiting period. Your monthly LTD benefit would be 60% of your monthly earnings, reduced by other income you may receive. The waiting period is the amount of time that you are unable to perform your job duties before you begin to receive a benefit.

Newly hired employees, who enroll in a timely manner (within 31 days of) when they are first eligible for this Long-Term Disability plan, can elect one of the options without providing proof of good health, known as Evidence of Insurability.

If an employee has been eligible for the Long-Term Disability plan, but not participating in the plan, and later decides to add LTD coverage, Evidence of Insurability (EOI) will be required. Evidence of Insurability is provided to our insurance carrier by completing a questionnaire, and is subject to approval by our LTD insurance carrier.

The program is insured through The Standard. The employee pays the full premium for LTD coverage. The premium is based upon age and annual salary.

Life Insurance, Accidental Death & Dismemberment Coverage

CPS provides Basic Life Insurance coverage of $25,000 for each eligible employee. CPS also offers the following Supplemental Life Insurance coverage options for purchase:

Supplemental Employee Term Life Insurance, in amounts equal to one, two, three or four times your base annual earnings. The maximum amount of coverage available is $750,000.

- Supplemental Dependent Term Life Insurance, in the amount of $50,000 for your spouse and/or in the amount of $10,000 for each eligible child.
- Employee Accidental Death & Dismemberment (AD&D) coverage in an amount equal to the level of Supplemental Employee Term Life Insurance you have.
- Dependent Accidental Death & Dismemberment coverage in an amount equal to the level of Supplemental Dependent Term Life Insurance you have for your spouse and/or your eligible children.

To qualify for coverage on your eligible children, you must have some or any amount of Supplemental Employee Term Life Insurance. To qualify for coverage on your spouse, you must have at least $25,000 of Supplemental Employee Term Life Insurance. The coverage available for children is a flat amount of $10,000 per child under age 26 (and it may continue for a child age 26 or older if the child is disabled). The coverage available for a spouse is a flat amount of $50,000.

For some coverage increases, you will need to provide Evidence of Insurability (EOI) to The Standard by completing a medical questionnaire. Such an increase will become effective if The Standard approves your request after reviewing the information provided. Newly hired employees, who enroll in a timely manner when they are first eligible for this Life Insurance, may elect one, two or three times their annual earnings (to a maximum of $500,000) and add spouse Life Insurance without providing Evidence of Insurability.

The program is insured through The Standard Except for Basic Life Insurance, the employee pays the full premium, which is calculated based upon age and annual salary.

If your employment with CPS is ending, and you wish to continue any of the Life Insurance you had as an active CPS employee, call The Standard at (833) 960-1238 for Continuation Plan provisions and costs. Your acceptance in a Continuation Plan is guaranteed, as long as you apply within 45 days after your active employee Life Insurance ends.

Critical Illness Insurance

CPS offers group Critical Illness Insurance from Standard Insurance Company ("The Standard") to help cover out-of-pocket expenses that come with being very ill. A variety of illnesses are covered including heart attack, cancer, or stroke. The benefit goes directly to the insured or covered family member, not medical providers. Use it to cover the costs of groceries, childcare, or other expenses such as:

- Medical insurance deductible
- Doctor copays and coinsurance
- Out-of-pocket expenses
- Alternative treatments not covered under your medical plan
- Transportation to medical appointments and treatments
- Lodging near treatment facilities
- Spouse's lost wages

You can enroll for coverage for you and your family. **Visit CPS.edu/HR4U** for more information and to enroll.

Accident Insurance

CPS offers Group Accident Insurance from The Standard to help pay out-of-pocket costs following a covered accident. It covers a wide range of treatments due to an accident. The benefit goes directly to the insured or covered family member, not medical providers. Receive an extra 25% of total benefits for injuries during youth organized sports. Use it to cover the cost of deductibles, copays, or other expenses such as:

- Ground ambulance
- Emergency room visit
- CAT scan
- Hospital admission
- Five-day hospital stay
- Two physician follow-ups
- Physical therapy (two sessions)

You can enroll for coverage for you and your family. **Visit CPS.edu/HR4U** for more information and to enroll.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA) are designed to ease the burden of unexpected out-of-pocket medical expenses. We encourage all CPS employees to seriously consider setting up an account during Open Enrollment. An FSA allows you to contribute pre-tax earnings into a special account that can be used to pay for eligible medical and dependent care expenses. FSAs expire at midnight on December 31 every year.

Health Care and Dependent Care FSAs

CPS offers an FSA for health care expenses and another for dependent care expenses. You may enroll in the FSA Program without being enrolled in a medical or dental plan. Benefitexpress administers the FSAs. FSAs allow you to pay for a variety of expenses that you and your eligible dependents incur every year as described below.

Your contribution amount will be divided among the pay periods in the year. If you do not receive a paycheck during the summer, for example, your contribution amount will be readjusted based on the remaining pay periods once your checks resume.

HOW IT WORKS

There are two ways to file a claim for health care FSA expenses:

Point of Sale

For your co-payments and prescription drugs, you may use a debit card issued by Benefit Express to access your account.

Paper Submission

You may complete a benefit claim form and submit it to Benefit Express. Health-care FSA forms are available at www.cpsfsa.com.

Reimbursement is the only way to recover dependent care FSA expenses. Forms are available at CPSFSA.com.

You may submit a paper submission at any time after you have accumulated reimbursable expenses. All claims must be filed prior to March 31 following the end of the year in which the eligible expense was incurred.

Please note the following:

- Acceptance of card purchases or claims does not assure IRS acceptance of the expense as eligible for FSA reimbursement. It is your responsibility to make sure that expenses paid for with the Benefit Express health care expense card or that you submit for reimbursement are eligible for reimbursement under IRS rules.
- If you do not incur expenses equal to or exceeding the amount in your applicable FSA prior to the end of each calendar year, any remainder will be forfeited in accordance with federal law.

How to Keep Track of Your Account Balances

Your FSA account balances may be viewed online at **www.cpsfsa.com**. You will be required to create a personalized online account to access this information. You also may retrieve balance information telephonically by calling (877) 837-5017.

Claims Appeal Procedures

If you would like to appeal a denial of an FSA claim you must submit a written appeal within 180 days of the denial. It should include any additional facts and/or documents supporting approval of the claim. The appeal can be mailed to:

benefitexpress
P.O. Box 189
Arlington Heights, IL 60006
Attn: FSA Administrators

Or fax to benefitexpress at (253) 793-3766, Attn: FSA Administrators

Health Care FSA

The health care FSA can reimburse eligible expenses not covered by your basic medical or dental plan. Examples of eligible expenses include:

- Amounts paid for deductibles, co-payments and co-insurance.
- Amounts paid for prescribed medicine.
- Laser eye surgery.
- Orthodontia services.
- Prescribed smoking cessation programs.
- Maintenance prescriptions, vision exams and eyeglasses, hearing aids, medical and dental deductibles, co-pays and co-insurance and other services not covered by your medical benefits plan.

A more comprehensive list of eligible expenses is available at www.MyFSAExpress.com. You can also obtain this information from IRS Publication 502, available at www.irs.gov.

Per IRS regulations, employees cannot be enrolled in both the HSA plan and the Health Care FSA plans concurrently. It is against current IRS regulations to be covered under the PPO with HSA and contribute to the Health Care FSA plan. More information can be found in IRS Publication 969.

If you terminate, only claims incurred up to the termination date will be eligible for reimbursement. You may submit a paper submission at any time after you have accumulated reimbursable expenses. All claims must be filed prior to March 31 following the end of the year in which the eligible expense was incurred.

Minimum/Maximum Contributions to the Health Care FSA

To participate in the health care FSA, you must contribute a minimum of $25 and up to a maximum of $2,850 per calendar year.

The annual pledge amount will be divided equally among the remaining paychecks for the calendar year. For employees with 20 pay periods, the deduction amount will adjust after the summer months since no paychecks are generated during the break.

What is an FSA rollover?

Historically, FSA users would forfeit any unused FSA funds at the end of the plan year as a result of the use-it-or-lose-it rule. While this rule is still in place, the FSA rollover option provides you with a measure of relief by giving you the ability to roll over up to $550 of unused funds to the following plan year. The rollover amount does not count toward the maximum allowable contribution for the following plan year.

How does it work? Here's an Example:

- During open enrollment, you elect to contribute the maximum allowable amount of $2,850 to your FSA.
- During the course of the plan year, you spend $2,300 on eligible healthcare expenses, which means you have $450 remaining in your account at the end of the plan year.
- You choose to re-enroll in the FSA and expect to incur additional medical expenses in the coming year so you once again elect to contribute the maximum allowable amount of $2,850.
- Thanks to the FSA rollover option, the $450 of unused funds from your previous year's account is added to your current year account.
- You now have $3,200 available for qualified healthcare expenses for the current year.

What are the benefits of the FSA rollover option?

- Minimizes your risk of forfeiting unused FSA funds at the end of the plan year.
- You no longer have to precisely predict your out-of-pocket healthcare expenses for the coming year in an effort to choose the "right" FSA election amount during open enrollment.
- Gives you more flexibility to pay for eligible healthcare expenses as they arise, rather than rushing to spend all unused FSA funds at the end of the plan year.

Dependent Care FSA

The dependent care FSA can reimburse you for certain expenses you pay so you can work. Some examples of eligible dependent care expenses include:

- Day care for your eligible children or adult dependent.
- Babysitters for your eligible child while you work, in or out of your home.
- Housekeepers who primarily care for your eligible child or adult dependent.
- Fees for a licensed elder day care center for an adult dependent.
- Fees for a child care center or nursery school for an eligible child.
- Summer day camp for your qualifying child under age 13.

Expenses for the following dependents may be eligible for reimbursement:

- A child under age 13 in your custody whom you claim as a dependent on your tax return
- A legal spouse, as defined under federal law, who is physically or mentally incapable of self-care
- A dependent who lives with you – such as a child age 13 or older, parent, sibling, in-law or a legal spouse who does not meet the federal law definition of "spouse" who is physically or mentally incapable of self-care, and whom you claim as a dependent
- If care is provided outside of your home for a spouse or dependent age 13 or older, either of whom is incapable of self-care, the spouse or dependent must live in your home at least eight hours per day.

How long do I have to use my dependent care flexible spending account?

As an active employee, you may use the dependent care FSA funds up through the last day of the calendar year. You may submit a paper submission at any time after you have accumulated reimbursable expenses. All claims must be filed prior to March 31 following the end of the year in which the eligible expense was incurred.

If you terminate, only claims incurred up to the termination date will be eligible for reimbursement. You may submit a paper submission at any time after you have accumulated reimbursable expenses. All claims must be filed prior to March 31 following the end of the year in which the eligible expense was incurred.

Minimum/Maximum Contributions to the Dependent Care FSA

To participate in the Dependent Care FSA, you must contribute a minimum of $25 annually. IRS rules limit the amount of money you can put in a dependent care FSA each calendar year. You may contribute up to the lesser of:

- $5,000 per plan year ($2,500 if you are married and filing a separate income tax return)
- Your total earned income
- Your spouse's total earned income (you may not contribute to the dependent care FSA if your spouse's earned income is $0 and your spouse is capable of self-care or is not a full-time student).

Please note that the maximum amount that you can contribute to the dependent care FSA is the same whether you have one or more than one eligible dependents. If you choose to have eligible dependent care services reimbursed by your FSA, they cannot be claimed for a dependent care tax credit on your federal income tax return. Depending on your family's total annual income, a dependent care FSA may save you more. You should consult with a tax advisor to see which option is best for you.

Refer to IRS Publication 503, available at www.irs.gov for more information.

The annual pledge amount will be divided equally among the remaining pay-checks for the calendar year. For employees with 20 pay periods, the deduction amount will adjust after the summer months since no paychecks are generated during the break.

Supplemental Retirement

403(b) and 457 Programs

The district's retirement program was established under Section 403(b) and 457 of the Internal Revenue Service Code. They are exclusive to employees of tax-exempt organizations such as public schools. Millions of Americans take advantage of these savings programs every year, as there are few today that defer income taxes.

It is up to you what percentage of your gross annual earnings you wish to contribute pre-tax into your retirement account. Both the 403(b) and 457 tax-deferred compensation programs can be tailored to meet your investment objectives. Participants choose their investment plans from AIG.

Differences between 403(b) and 457 Plans

	403(b)	457 Plan
When you can begin taking distributions without penalty	Age 59½	Whenever you retire or whenever your employment with CPS ends, regardless of age.
Penalty for early withdrawals	10 percent penalty on the sum in addition to the income tax you will pay on the disbursement.	You may not withdraw funds prior to ending your employment with CPS.
Age at which you must begin taking distributions	Age 70½	Age 70½
Taxation	Disbursements are subject to income tax.	Disbursements are subject to income tax.
Minimum payroll deduction to start account	$10 per pay period	$10 per pay period
Contribution limits if you are under age 50	$20,500 for 2022	$20,500 for 2022
Contribution limits if you are over age 50	Additional "catch-up" contribution of $6,500 is permitted, for a total limit of $27,000. In addition, if you have at least 15 years of service with CPS, you may be eligible to contribute up to an additional $3,000 of pensionable earnings each year. Please check with AIG, the record keeper and fund provider, to determine eligibility.	Additional "catch-up" contribution of $6,500 is permitted, for a total limit of $27,000

Unused Sick Day/403(b) Contribution:	As of July 1, 2004, CPS contributes, on behalf of eligible retirees, the value of their eligible unused sick pay to the 403(b) Plan. The contribution of a retired employee who is currently enrolled in the 403(b) Tax-Deferred Compensation Program shall be made to the Program Service Provider(s) to which the participant most recently allocated his/her salary reduction agreement.
Contribution for a Participant Currently Enrolled	a) The contribution of a retired employee who is currently enrolled in the 403(b) Tax-Deferred Compensation Program shall be made to the Program Service Provider(s) to which the participant most recently allocated his/her salary reduction agreement. b) A letter will be sent to the participant stating the amount that represents the participant's available unused sick days, as of the date of retirement. c) The unused sick day contribution will be sent within 60 days from the date of this letter.
Contribution for a Participant Not Currently Enrolled	a) The contribution of a retired employee who is not currently enrolled in the 403(b) Tax-Deferred Compensation Program will be sent a letter notifying him/her of the retired employee's eligibility to receive a contribution. b) The letter represents the amount of the participant's available unused sick days, as of the date of retirement and will be sent within 60 days from the date of this letter.
Contribution Amount	a) The maximum contribution is $80,000. b) If a retired employee has more than $80,000 in accumulated sick pay, the excess will be paid directly to the retired employee. c) The maximum annual contribution limit is $61,000. If the retired employee is currently contributing to a 403(b) plan, the amount will be subtracted from the $61,000.

Bright Start College Savings

Oppenheimer Funds offers parents an easy and convenient way to start their children's college funds through payroll deductions. For more information and enrollment instructions call (800) 655-4853 or visit **www.brightstartsavings.com**.

Maintaining Benefits During a Leave of Absence

Benefits Billing provides eligible employees with ways to sustain health benefits coverage if they go on a leave of absence or experience another interruption in work.

Benefits Billing allows employees who are temporarily off the payroll, on an approved Leave of Absence (LOA), to continue to make their medical contribution directly to the Health and Benefits Team via the Benefits Billing vendor.

COBRA allows employees who have been terminated or whose hours have been reduced to continue their medical plan coverage by paying the full premium plus a 2% administrative fee. The full premium is the monthly amount that the Board pays for health insurance plus the employee's contribution.

Benefits Billing

The Board contributes a major portion of the cost of medical and dental coverage for eligible employees. Your share of the cost is deducted from your paycheck on a pre-tax basis, according to Sections 105, 106 and 125 of the Internal Revenue Service Code. The Benefits Billing program allows employees who are temporarily off the payroll on an approved LOA to continue to make their contributions directly to the benefits billing lockbox.

The Absence and Disability Department will send you a notice and billing statement if you are eligible for Benefits Billing. Your period of eligibility will be determined by the Absence and Disability Department. If you receive a paycheck and your deduction for medical coverage was not taken, you will be billed for each pay period you miss.

Cost

While you are enrolled in the Benefits Billing program, your contributions are based on a monthly premium amount. The amount of your contribution will be indicated on each coupon or billing statement.

Billing Process

You will be sent benefit billing statements with the due date indicated on each statement. Payments must be made directly to the benefits billing lockbox address indicated on your benefit billing statement. Payment must be in the form of a Check or Money Order. Cash will not be accepted. You must submit your coupon with your check or money order.

Grace Period	Your payment due date is indicated on each coupon. In accordance with the Family and Medical Leave Act, you have an additional 16-day Grace Period. If you do not pay your Benefits Billing contributions by the due date, your coverage may be terminated until your balance has been paid in full. A notice will also be sent to your provider.
NSF Payments	If you pay with a check that is returned for Non-Sufficient Funds (NSF) or can otherwise not be processed, your account will be treated as though you failed to make payment and all the rules of non-payment will apply. In accordance with current CPS policy, you will be charged a $34 service fee. You will be required to replace the check with a Money Order or a Certified Check. If you fail to replace a bad check by the end of the grace period, you will be responsible to your provider for any health claims and expenses incurred during that period and your coverage will be terminated.
Outstanding Payments	When you return to work you must pay your Benefits Billing account in full if you want your benefits to be reinstated. If you cannot pay your balance in full you can request a Wage Authorization form so that bi-weekly deductions can be withdrawn from your paycheck until you satisfy your balance. If there are any pay periods for which your account is more than 30 days past due, you will be responsible for any health claims and expenses incurred during those periods. Your provider will be notified and directed to bill you for any expenses incurred for any periods for which you have not made payment.
Coverage	You will have all the same health plans, at the same coverage level (Single, Employee +1 or Family), that you had the pay period prior to your LOA. Your eligible family members will continue coverage while you are under this program. The maximum period for continued medical is based on the Chicago Board of Education Rules or your Collective Bargaining Agreement.
Coverage and Changes	You may add a spouse or dependents if you have a change in Family Status as outlined in the Chicago Board Of Education Pre-Tax Contribution Plan (Internal Revenue Code Section 125) or during Open Enrollment. You may change your provider during Open Enrollment, subject to Open Enrollment rules.
Return to Work	You will receive an email notification from the Absence and Disability Department once you have been cleared to return to work. Once reinstated, you will be removed from Benefit Billing effective the first of the following month.

How to reinstate benefits upon return to work:

1) Reach out to the Health and Benefits team at healthandbenefits@cps.edu to notify Health and Benefits of your return to work date.

2) Complete the Benefits Enrollment/Reinstatement form (provided to you by the Health and Benefits department).

3) Submit the Benefits Enrollment/Reinstatement form to the Health and Benefits Department.

To submit your documentation via fax or scan, you will need to access your personalized Scanning Cover Sheet by navigating to **CPS.edu/Staff then click on the link for HR4U**. Fill it out and submit it with your documents either by fax to 773-553-4DOC or by scan to benefitdocuments@cps.edu.

4) Your benefits effective date is the first of the month following your return to work date.

Benefits Billing Address

JPMorgan Chase
Attn: CPS Benefits Billing
28541 Network Place
Chicago, IL 60673-1285

COBRA

CPS offers you and your covered family members an opportunity to continue medical, dental and vision coverage after your employment with CPS ends. In accordance with the Public Health Service Act (PHSA), commonly known as COBRA, when coverage is lost due to termination of employment (except for gross misconduct) or a reduction in work hours, you and your covered family members are eligible to continue coverage under PHSA. If you are not enrolled in a medical or dental plan on the day your employment terminates or your work hours are reduced, you do not have a right to elect coverage under PHSA.

PHSA also provides for continuation of medical, dental and vision coverage for a covered spouse due to:

- Death
- Divorce
- Legal separation

PHSA provides continuation coverage for a dependent who loses coverage because he/she is no longer eligible under rules of the plan. COBRA is administered by Payflex, which may be reached at (800) 359-3921.

In accordance with the Public Health Service Act, when coverage under the Medical Plan ends, you and your covered dependents may be eligible to continue your medical benefits at your own expense for a temporary period. To be eligible, a "qualifying event" causing the loss of coverage must occur. The following chart shows who is eligible to continue coverage under the plan and how long coverage may continue.

Qualifying Event (reason coverage ended)	Who May Continue	Maximum Coverage Period
Your termination or layoff.	You, spouse and dependents	18 months*.
Your hours are reduced resulting in loss of coverage.	You, spouse and dependents	18 months*
You divorce or legally separate.	Spouse and dependents	36 months
Your dependents are no longer eligible when they reach the limiting age.	Dependents	36 months
You drop out of the plan because you choose Medicare as primary coverage.	Non-Medicare eligible spouse and dependents	36 months
You die.	Spouse and dependents	36 months

*** If you or a dependent is disabled at the time of the qualifying event, coverage may be continued for up to a total of 29 months.**

What Happens to my Benefits if I Terminate?

Medical	Your coverage ends on the last day of the month in which you terminate
Dental	Your coverage ends on the last day of the month in which you terminate.
Vision	Your coverage ends on the last day of the month in which you terminate.
Flexible Spending Account (FSA)	You may incur claims up to the last day worked. You have until March 31 of the next year to be reimbursed for claims incurred in the previous year.
Health Savings Account (HSA)	You may use your available funds.
Short-Term Disability	Your coverage ends the same day as your last day worked.
Long-Term Disability	Your coverage ends the same day as your last day worked.
Life Insurance (Employee and Dependents)	Your coverage ends the same day as your last day worked.
Supplemental Retirement Plans 403(b) or 457	Voluntary payroll contributions will end on the last paycheck containing the last day worked. Contact your vendor for information about transactions.

Family and Medical Leave Act

Employee Rights and Responsibilities

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or childbirth
- To care for the employee's child after birth, or placement for adoption or foster care
- To care for the employee's spouse, son, daughter or parent, who has a serious health condition
- For a serious health condition that makes the employee unable to perform the employee's job

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or called to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period.

A Covered Service Member is:

1. A current member of the armed forces, including a member of the national guard or reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or
2. A veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition."**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any group health plan on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements	Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles. ***Special hours of service eligibility requirements apply to school-based employees.**
Definition of Serious Health Condition	A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.
Use of Leave	An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.
Substitution of Paid Leave for Unpaid Leave	Employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.
Employee Responsibilities	Employees must provide 30 days' advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures. Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Parental Leave

Paid Parental leave offers 10 consecutive paid days to an FMLA eligible employee who is the non-birth parent to care for a child after the child's birth or adoption by the employee, the spouse, civil union or domestic partner of the employee. An eligible employee is any regular full-time employee who works for Chicago Public Schools for at least 12 months before taking the leave and has worked 1250 hours in a rolling 12-month period. Employee must be eligible to take an FMLA leave in order to qualify for this leave.

- An employee can receive 100% of base pay for up to ten (10) consecutive work days.
- Paid parental leave runs concurrently with any unpaid FMLA leave and will be administered in conjunction with the Family Medical Leave Act of 1993.
- Parental leave must be taken within 1 year of the child's birth or adoption and cannot be taken more than one (1) time in a rolling 12-month period.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
Call: (866) 4US-WAGE (866) 487-9243
TTY: (877) 889-5627

WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

Subrogation

Right of Recovery

If the plan provides benefits for injury, illness, medical care or other loss to any person, the plan is entitled to claim its share of any present and future compensation that person, his parents, heirs, guardians, executors or other representatives (individually and collectively called the "participant") may receive as a result of the injury or loss.

Those subrogation rights include, without limitation, all rights to recovery a participant has:

- Against any person, insurance company or other entity that is in any way responsible for providing or does provide damages, compensation, indemnification or benefits for the injury
- Under any law or policy of insurance or accident benefit plan providing no fault, personal injury protection or financial responsibility insurance
- Under uninsured or underinsured motorist insurance
- Under motor vehicle medical reimbursement insurance
- Under specific risk or group accident and health coverage or insurance, including, without limitation, premises or homeowners medical reimbursement, athletic team, school or workers' compensation coverage or insurance.

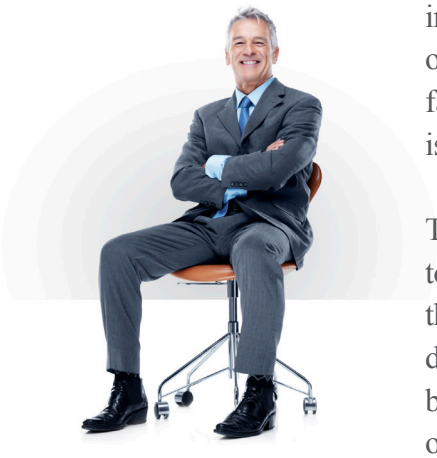
Upon notice of an injury claim, the plan may assert a subrogation lien to the extent it has provided, or may be required to provide, injury-related benefits. Notice of either the plan's right of subrogation or the plan's subrogation lien is sufficient to establish the plan's rights of subrogation and entitlement to claim reimbursement from insurers, third parties, or other persons or entities against whom a participant may have an injury-related right of recovery. The plan shall not be required to intervene in any litigation in order to enforce its subrogation rights. The plan is authorized, but not required, to institute legal action in its name and/or in the name of the participant in order to enforce the plan's subrogation rights.

The participant and anyone acting on his behalf shall promptly provide the plan or its authorized agents with information to protect its rights of subrogation and shall do nothing to impede enforcement of those rights. The amount of the plan's subrogation claim shall be deducted first from any recovery by or on behalf of the participant. Neither a participant nor his attorney or other representative is authorized to accept subrogation or other injury-related reimbursement payments on behalf of the plan, to negotiate or compromise the plan's subrogation claim, or to release any right of recovery prior to the payment of the plan's subrogation claim.

Right of Recovery (cont.)

The participant and all other parties to a recovery are required to contact the plan to determine, and arrange to pay, the plan's subrogation claim at or prior to the time an injury-related payment or settlement is made to or for the benefit of the participant. If the participant obtains a payment or settlement is made to or for the benefit of the participant.

If the participant obtains a payment or settlement from a party without the plan's knowledge and agreement, the plan shall be entitled to immediate reimbursement of its total subrogation claim from the participant or any party providing any injury-related payment. In addition, the plan may deny payment of benefits to or on behalf of the participant or any otherwise eligible member of the participant's family for any otherwise-covered claim until the amount of the unpaid coverage is equal to and offset by the unrecovered amount of the plan's subrogation claim.



The plan administrator or its authorized agents are vested with full authority to construe subrogation and other plan terms and to reduce or compromise the amount of the plan's recoverable interest where warranted, in the sole discretion of the plan administrator or its authorized agents. The plan shall not be responsible for any litigation-related expenses or attorney fees incurred by or on behalf of a participant in connection with an injury claim unless the plan specifically agrees in writing to pay such expenses or fees.

The payment of benefits to or on behalf of the participant is contingent on both the participant's full compliance with the plan's provisions, including the subrogation provision, and, when the plan deems appropriate, the participant's signing of a reimbursement agreement. However, the participant's failure to sign this reimbursement agreement will not affect the plan's subrogation rights or its right to assert a lien against any source of possible recovery and to collect the amount of its subrogation claim.

Glossary

The following phrases are used throughout this Handbook. Some of them are general terms that have specific meaning in the language of benefits.

Health and Benefits Team	CPS employees who can assist you in understanding your benefits
Board	Board of Education of the City of Chicago
Civil Union Partner	A partner of a CPS employee with whom the employee has entered into a relationship that is identified by a certified civil union certificate duly recognized by the state in which the certificate was granted
Claims Administrator	BlueCross and BlueShield of Illinois
Co-Insurance	After you meet the annual deductible, where it applies, the plan will pay a percentage of covered expenses; you pay the remaining portion. Your share is called your co-insurance.
Co-Pay	You will be required to pay a small fee each time certain services are received. This co-payment, which is not part of your deductible, may vary, depending upon the type of service received
Coordinated Home Care Program	An organized skilled patient care program in which care is provided in the home. Care may be provided by a hospital's licensed home health department or by other licensed home health agencies. You must be unable to leave the home without assistance and require supportive devices or special transportation and you must require skilled nursing service on an occasional basis under the direction of your doctor to qualify for coordinated home care. The program includes skilled nursing service by a registered professional nurse, the services of physical, occupational and speech therapists, hospital labs and necessary medical supplies.
Covered Service	A service or supply for which benefits will be paid.

CRNA	A Certified Registered Nurse Anesthetist who: • Is a graduate of an approved school of nursing and is licensed as a registered nurse • Is a graduate of an approved program of nurse anesthesia accredited by the council of accreditation of nurse anesthesia education programs/schools • Has been certified by the council of certification of nurse anesthetists • Is recertified every two years by the council on recertification of nurse anesthetists.
Custodial Care	Care that is provided at a nursing facility or at home when a patient's condition is such that further progress is not expected and medical treatment is not provided. Custodial care is mainly provided to help the patient with daily living activities, such as walking, bathing, dressing, eating with a spoon, tube or gastrostomy. Custodial care also includes care that could be provided safely and reasonably by a person who is not medically skilled.
CPS	Chicago Public Schools. All persons employed at Chicago Public Schools are employees of the Board.
CTU	Chicago Teachers Union
Deductibles	The deductible, where it applies, is the portion of your medical expenses that you pay each year before the plan pays benefits. If you and one dependent are covered by the plan, each of you must meet the individual deductible. If you have family coverage, three members of the family must satisfy the deductible. In addition, if two or more members of your family obtain covered services as a result of injuries suffered in the same accident, expenses for those services will be applied to only one deductible.
Family Status Change	A change in an employee's personal situation that permits her/him to make a change in medical and dental coverage outside of Open Enrollment, provided that the Health and Benefits Team is notified promptly, as specified in this Handbook. Additional information regarding Family Status Change is available in the "Eligibility" section of this handbook.

Emergency Accident Care	The initial outpatient treatment of accidental injuries, including related diagnostic service, which have severe symptoms. If immediate medical attention is not obtained, the injury could result in serious and permanent medical consequences. Examples of such injuries include fractures and concussions.
Emergency Medical Care	The initial outpatient treatment of accidental injuries, including related diagnostic service, of the sudden and unexpected onset of a medical condition that has severe symptoms. If immediate medical attention is not obtained, the symptoms could result in serious and permanent medical consequences. Examples of such symptoms are severe chest pains, convulsions or persistent, severe abdominal pains.
Inpatient	A registered bed patient treated as such in a hospital, skilled nursing facility or hospice unit.
Investigational	Procedures, drugs, devices, services and/or supplies that: • Are provided or performed in special settings for research purposes or under a controlled environment and that are being studied for safety, efficiency and effectiveness; • Are awaiting endorsement by the appropriate national medical specialty college or federal government agency for general use by the medical community at the time they are provided to you; and • Specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the federal drug administration at the time used or administered to you. The Claims Administrator will initially determine if a service or supply is medically necessary. The plan will not pay for the cost of hospital stays or any other health care services or supplies that are not medically necessary. The judgment of the Claims Administrator relates only to benefit coverage under this plan. You should not use the availability of benefit coverage to determine what medical care or treatment you or your dependents decide to receive.

Open Enrollment	A period that occurs once per year, normally during fall, when eligible employees choose whether and how they will participate in the various benefits plans being offered for the following year; they also may add or drop covered dependents and coverage. Absent a qualifying family status change as described in this Handbook, Open Enrollment is the only time when employees are permitted to change their benefit elections, and the elections may be subject to certain additional conditions or approvals. Elections that are approved that are made during Open Enrollment become effective the following Jan. 1.
Out-of-Pocket Maximum	PPO plans cap the amount of money you will have to pay for eligible medical expenses incurred each year. Once you reach the out-of-pocket maximum via the deductible and your share of expenses for covered services, the PPO plans will pay 100% of eligible in-network medical expenses for the rest of the calendar year. Expenses incurred out-of-network do not count toward the out-of-pocket maximum. You will continue to pay a percentage of covered expenses. The following expenses cannot be applied to the out-of-pocket maximum and will not be paid at 100% once the out-of-pocket maximum is reached: • Charges that are greater than the eligible charge or maximum allowance • Charges for covered services that have a separate dollar maximum • Co-payments that result when you do not follow the provisions of the pre-treatment review program • Prescription drug co-payments • Vision care co-payments • Office visit co-payments If you and one dependent are covered by the plan, each of you must meet the individual out-of-pocket maximum. If you have family PPO coverage, two individuals must each meet the out-of-pocket maximum.
Plan Year	The period from Jan. 1 up to and including Dec. 31 of each year.
Prescription Drugs	Drugs or medicines that require a doctor's signature to dispense and are approved by the U.S. Federal Drug Administration for use in treating the sickness or injury for which they are prescribed.
Skilled Nursing Facility	A licensed institution (other than a hospital) that specializes in inpatient physical rehabilitation, skilled nursing or medical care. The skilled nursing facility must: • Maintain all facilities necessary for medical treatment • Provide treatment under the supervision of doctors • Provide nursing services 24 hours every day • Maintain daily clinical records on all patients. **NOTE: A skilled nursing facility does not include any institution or part of an institution that is used primarily for educational care, custodial care, or for the care and treatment of drug addiction or alcoholism.**

Authenticating and Submitting Enrollment Documents

Before you submit, complete your personalized benefits documentation cover sheet, available by logging into **CPS.edu/Staff then click on the link for HR4U** (see sample on next page). This cover sheet is required to certify your documents and process your benefits elections.

There are four ways to submit your documents and required personalized cover sheet.

By scan to benefitdocuments@cps.edu
By fax to (773) 553-4DOC (4362)
By drop box located on the main floor of the Benefits Office at 2651 W. Washington Blvd., near the security station, Monday-Friday from 8 a.m. to 5 p.m.
By mail to Health and Benefits, 2651 W. Washington, Chicago, IL. 60612

Note: Drop box submissions must contain original certified documents. Originals will be mailed back to your address on file. Your elections cannot be processed without your personalized benefits documentation cover sheet. For new hires, documentation must be submitted within 31 days of your hire date to complete processing.

Sample of the Benefit Documentation Cover Sheet

This is only a sample of the personalized Benefit Documentation Cover Sheet

CPS TALENT OFFICE
FAX/ EMAIL
BENEFIT DOCUMENTATION COVER SHEET

Please use this cover sheet when faxing or e-mailing your benefit documentation. This sheet must go on top as a cover sheet accompanied by your documents. The Employee Identification bar code must be legible. Be sure to sign the form and complete all information. Thank you!

TO: Chicago Public Schools - Talent Office
Health and Benefits Department

Phone: 773-553-HR4U (4748)
Fax: 773-553-4DOC (4362)
Dial the entire fax telephone number
E-Mail: BenefitDocuments@cps.edu

Name:

Employee ID:

Life Event:

Benefit Form:

Document Type:

If you have selected multiple documents and/or multiple forms please specify what documents you are submitting, in the comments box below.

Comment:

Attestation Clause: *I certify that the attached documents are authentic and have been issued by the local, state, county or federal agency indicated. I understand, consent and agree that if any of the attached or this declaration are found to be false, my employment shall be subject to immediate termination.*

Signature:_____

Date:_____

Vendor Contacts

The Health and Benefits Team is your primary resource for benefits questions. If you have questions about claims, doctors, or hospital locations, you may contact one of our providers.

Provider/Group Number	Phone Number	Address	Website
BlueCross BlueShield BlueAdvantage HMO (Medical) B12709	(866) 248-3092	P.O.Box 1364 Chicago, IL 60690	www.bcbsil.com/members
BlueCross BlueShield PPO (Medical) P12709	(800) 331-8032	P.O.Box 2352 Chicago, IL 60690	www.bcbsil.com/members
BlueCross BlueShield PPO with HSA (Medical) 191904	(800) 331-8032	P.O.Box 2352 Chicago, IL 60690	www.bcbsil.com/members
Delta Dental HMO/PPO (Dental) 10083	(800) 323-1743	P.O.Box 5402 Lisle, IL 60532-5402	www.deltadentalil.com
Caremark (Prescription Carrier) CPSRX	(866) 409-8523	P.O.Box 686005 SanAntonio, TX 78268-6005	www.caremark.com
EyeMed Vision Care (Vision Plan) Insight	(855) 347-6900	4000 Luxottica Place Mason, Ohio 45040	www.eyemed.com
The Standard (Optional Life Insurance, Accidental Death & Dismemberment, Beneficiary Designations, Evidence of Insurability Status, Accident Insurance, Critical Illness, Long Term Disability)	(833) 960-1238		http://standard.com/
Magellan (Employee Assistance Program)	(800) 424-4776		www.magellanascend.com
Benefitexpress (Flexible Spending Accounts)	(877) 837-5017	220 W. Campus Dr. Suite 203 Arlington Heights, IL 60004	www.CPSFSA.com
BrightStart (College Savings Program)	(800) 655-4853		www.brightstartsavings.com
AIG	(312) 214-8888	500 W Madison, Suite 2850 Chicago, IL 60606	www.valic.com/CPS
HSA Bank (Health Savings Account)	(855) 731-5220	605 N. 8th St. Ste 320 Sheboygan, WI 53081	https://hcsc.hsabank.com