BE WELL
Chicago Public Schools

YOUR 2025 BENEFITS

CPS benefits: In a class of their own

Welcome to Chicago Public Schools, where our standard is excellence – for our students and our staff, in the classroom, and beyond.

As a cornerstone of our commitment to your success, we prioritize your well-being, vitality, and peace of mind. The best-in-class health, wellness, and financial benefits we offer to you and your family reflect this value. We are proud to provide a benefits package that features choice, flexibility, and affordability so you can customize your benefits in the way that best supports you.

This guide details all of the benefits available to you, from your medical plan options to retirement savings and just about everything in between. Please take the time to review your options carefully and don't hesitate to reach out to our team of benefits specialists with questions.

We are in this together!

Chicago Public Schools

Click on the logo to come back to this page.

Your benefits at Chicago Public Schools

Click on a benefit to see more.

Medical
Enroll during OE · Shared cost

Prescription Drug
Enroll during OE · Shared cost

Health Savings Account (HSA)
Enroll during OE · Shared cost

Dental
Enroll during OE · Shared cost

Vision
Enroll during OE · Shared cost

Behavioral Health Programs
Access anytime · Shared cost

Wellness Program
Access anytime · Included with Medical

Flexible Spending Accounts (FSAs)
Enroll during OE · Paid by you

Short-Term Disability
Auto-enrolled · Paid by CPS

Long-Term Disability
Auto-enrolled · Paid by CPS

Life Insurance and AD&D Coverage
Auto-enrolled · Paid by CPS

Critical Illness Insurance
Enroll anytime · Paid by you

Accident Insurance
Enroll anytime · Paid by you

Hospital Indemnity Insurance
Enroll anytime · Paid by you

Supplemental Retirement
Enroll anytime · Paid by you

College Savings Program
Enroll anytime · Paid by you

The Employee Assistance Program (EAP)
Auto-enrolled · Paid by CPS

Eligibility and Enrollment

In this section:

Eligibility and Enrollment

Who Can I Enroll?

Yourself, if you are:

- ✓ An employee of the Board/CPS who works at least 30 hours each week, have full-time status or are a regularly assigned teacher, other than temporary or seasonal.
- ✓ An employee of the Board/CPS who is represented by Local No. 1 or Local No. 73 and regularly works at least 15 hours each week.
- ✓ An employee of the Board/CPS who is represented by the CTU and who regularly works at least 15 hours each week.

Your dependents (when dependent coverage is available), if they are:

- ✓ A legal spouse or civil union partner.
- ✓ A dependent child under the age of 26, including natural children, stepchildren, legally adopted children and/or children under the employee's legal guardianship.
- ✓ A dependent child age 26 to 30 who was honorably discharged from the military and resides in Illinois.
- ✓ A child of any age who depends on the employee because of physical or mental handicap.*

*Rules regarding prior coverage and documentation apply. Please contact healthandbenefits@cps.edu to verify eligibility and documentation.

Eligibility and Enrollment

When Can I Enroll?

You can enroll for benefits:

- Within 31 days of your hire date. Your coverage begins the first of the month following your date of hire.
- During Open Enrollment
- If you experience a qualifying life event.

What if you don't enroll?

If you do not enroll for coverage within 31 days of your hire date or during Open Enrollment:

- You will not be able to enroll until the next Open Enrollment and your coverage will not take effect until the following January 1.

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.

Eligibility and Enrollment

Can I Change My Benefits?

You are allowed to change your benefits if you have a qualifying life event, such as:

- **Change of legal marital status:** Marriage, divorce, establishment/termination of a civil union, termination of an existing grandfathered domestic partnership, death.
- **Change in employment status:** 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.
- **Change in number or status of dependents:** Birth, adoption, placement for adoption or death of a dependent; change in age or other qualifying criterion of dependent.
- **Change in domestic relations orders:** 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.
- **Change in work schedule:** 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.
- **Gain or loss of Medicare and Medicaid:** 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 they are age 65 or older, eligible for Medicare and is covered by a Board-sponsored plan.
- 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.

You have 31 days from the life event to make changes to your coverage. The benefits changes you make must be related to your life event.

Any benefits 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.

*Documentation is required. See page 10 for documentation requirements. Do not wait until you receive the document(s), however, to notify the Health and Benefits Team. If you think you have a qualifying family status change, immediately contact the Health and Benefits Team for more information.

Eligibility and Enrollment

How Much Do Benefits Cost?

How much do your benefits 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. You won't pay any federal or state taxes (or Medicare taxes if they apply) on your premiums.

Look for these boxes throughout this guide

How much you pay per-paycheck	
Employee only	$
Employee +1	$
Family	$

Eligibility and Enrollment

Enrollment Exceptions

Dual Eligibility

You cannot be covered 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

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.
- 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 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.

For more information about your employer-paid short-term disability benefit, please review the LOA Handbook on the Absence and Disability website. If you have additional questions about the benefit, contact the Absence and Disability Department at cpsloa@cps.edu or (773) 553-4748.

Eligibility and Enrollment

Required Documentation

Documentation
To ensure compliance, you must provide documents verifying eligibility for your dependents and for qualifying life events.

- The district considers submission of documents falsifying a person's eligibility to obtain healthcare coverage an act of fraud.
- 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. You will also be held responsible for any PPO claims or HMO premiums paid on behalf of an ineligible person.

Non-translated Documents
Your affidavit must be a certified copy, which verifies that it has been filed by the governmental unit that has jurisdiction over issuing such a document; a certified copy generally has a raised or multi-colored seal or is issued on multi-colored paper. Foreign documents must be issued by a governmental unit and, if not in English, must be accompanied by an English translation either 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.

Where do I submit documentation?

Submit your benefits documentation to the Talent Office at benefitdocuments@cps.edu or fax it to (773) 553-4DOC.


CPS TALENT OFFICE
FAX/ EMAIL
BENEFIT DOCUMENTATION COVER SHEET

Include this cover sheet with your documentation. Your cover sheet is bar-coded to your CPS identification number.

- If emailing your documentation: Print, sign, and attach along with your other documentation.
- If faxing your documentation: Print, sign, and place on top of your other documentation.

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Eligibility and Enrollment

Required Documentation

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.

Dependent	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.)	CPS disabled dependent certification form (0-26 yrs.) A child with disabilities who depends on you for support or maintenance because of their physical or mental handicap will be covered if you provide proof of incapacitation prior to the child's 26th birthday (subject to determination of incapacitation by the Health and Benefits Team, or a medical review firm). Forms are available from the Health and Benefits Team. If you are a new hire or electing coverage due to a family status change, you may add disabled dependents age 26 and older when electing coverage for the first time and the age limit for submitting documentation will not apply. However, you must provide proof that the child was disabled prior to their 26th birthday and that the child was continuously covered by group health coverage since their 26th birthday.

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Eligibility and Enrollment

Required Documentation

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.

Dependent	Document(s) needed
Unmarried military dependent children who are residents of Illinois (ages 26 - 30)	Unmarried dependent children between the ages of 26 and 30 who are military veterans may be covered as dependents if they meet the criteria of dependency established for children under the age of 26 and: • They served in the active or reserve components of the U.S. Armed Forces, including the National Guard • They received a release or discharge other than a dishonorable discharge • You provide an original certified birth certificate and proof of parental relationship (as outlined on the previous pages) • You provide 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.
Unmarried military dependent children who are residents of Illinois (ages 26 - 30)	The cost to continue coverage for a military veteran dependent is 100% of the cost of coverage (your portion plus the state/employer contribution), regardless of the number of dependents enrolled in your coverage (find more info here).

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Eligibility and Enrollment

Required Documentation

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.

Dependent	Document(s) needed
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.

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Eligibility and Enrollment

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

Required Documentation

Dependent	Document(s) needed
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 same-sex domestic partner. **Your affidavit must meet the minimum requirements listed below:** • You and your partner are at least 18 years of age and reside at the same residence; • Neither you nor your partner is married (if you or your partner were previously married, proof of dissolution marriage is required); • You and your partner are not related by blood closer than would bar marriage in the State of Illinois; • You and your partner are each other's sole domestic partner, responsible for each other's common welfare; • 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.

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Eligibility and Enrollment

Required Documentation

Dependent	Document(s) needed

Domestic partner	**AND at least two of the following four conditions must apply and proof must be submitted:**
	• You and your partner have been residing together for at least twelve (12) months prior to filing the Affidavit of Domestic Partnership.
	• You and your partner have common or joint ownership of a residence.
	• You and your partner have at least two of the following arrangements:
	  • Joint ownership of a motor vehicle;
	  • Joint credit account;
	  • Joint checking account;
	  • Lease for residence identifying both you and your partner as tenants.
	• You declare your partner as a primary beneficiary in your will.

If your domestic partner becomes ineligible for benefits, you must notify the Health and Benefits Department in writing within 31 days. Certain limitations apply to continuing coverage for a domestic partner; contact the Health and Benefits Department for more information. Following termination of a domestic partnership, a minimum of 12 months must elapse before a new domestic partner may be designated.

Physical Health

In this section:

- Healthcare Terms Explained
- Medical Plans
- Medical Plan Contributions
- Medical Plans Compared
- Prescription Drugs
- Pre-Authorization
- Health Savings Account (HSA)
- Dental Plans
- Vision Plans
- Behavioral Health Resources
- Wellness Program

View All Benefits

Physical Health

Healthcare Terms Explained

Premium or contribution
The amount you pay for your health insurance every month.

In-network/Out-of-network
Each medical plan has a network of providers, including doctors and hospitals. Some medical plans cover both in- and out-of-network providers; others only pay when you stay in the network (unless it's an emergency). You will always pay less if you see a doctor or receive services within the provider network.

The easiest way to find which providers are in-network is to log in to the insurance provider's website or call the number on the back of your card.

Deductible
The amount you must pay for your care before the medical plan begins to cover a portion of your costs. The deductible is an important consideration when picking the right health plan for you.

Coinsurance
Once you have met your deductible, the medical plan begins to pay coinsurance — a percentage of covered expenses. You will pay the balance.

Copay
A fixed dollar amount for things such as a doctor visit that you pay at the time you receive care.

Out-of-pocket maximum
This is the maximum amount you will pay for healthcare costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will pay 100% for all eligible medical expenses.

Provider
Providers are people or places that deliver care. For example, a doctor, a dentist, a hospital, or a physical therapist.

See more healthcare terms at healthcare.gov/glossary

Physical Health

Are virtual visits available?

Yes, telemedicine/virtual visits are available, but only for PPO and PPO with HSA plan participants.

Medical Plans

We offer three medical plan options for you to choose from. All three plans are administered by Blue Cross Blue Shield of Illinois and share the same network. CPS shares in the cost of coverage for this benefit. Paycheck deductions will begin on the pay date following your effective date. However, if payroll has already been calculated, the new deduction may not be taken until the next pay date. See page 19 for medical plan costs.

Blue Advantage HMO

Key highlights of this plan

- Lower premiums
- No deductibles
- Doctor must be selected from preapproved list of doctors.
- Requires referral from your primary care doctor to see a specialist. Your primary care physician will manage and coordinate your care.

Traditional PPO

PPO with HSA

Key highlights of these plans

- Slightly higher premiums
- For the PPO Plan, there is a carry over deductible credit provision only when the deductible is met during the last two months of the calendar year. HSA plans are not eligible for the carry over deductible.
- Covers in-network and out-of-network doctors, **but in-network care will always cost less**.
- No referral is required to see a specialist, however pre-approval is required for certain services such as MRIs and CT scans.

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Physical Health

Medical Plan Contributions

Paycheck deduction is calculated based on salary, multiplied by the stated rate, and divided by the number of paychecks received.

Blue Advantage HMO

How much you pay per-paycheck	
CTU	
Employee only	2.75%
Employee +1	2.95%
Family	3.25%
SEIU Local 73, Teamsters Local 700, Electrical Workers 134	
Employee only	2.25%
Employee +1	2.45%
Family	2.75%
Eligible part-time teachers	
Employee only	5.5%
Employee +1	5.9%
Family	6.5%
Eligible non-union employees	
Employee only	3.5%
Employee +1	3.7%
Family	5.5%
UniteHere Local 1	
Employee only	2.1%
Employee +1	2.28%
Family	2.5%
SEIU Local 1	
Employee only	2.0%
Employee +1	2.2%
Family	2.5%

Traditional PPO

How much you pay per-paycheck	
CTU	
Employee only	2.95%
Employee +1	3.25%
Family	3.55%
SEIU Local 73, Teamsters Local 700, Electrical Workers 134	
Employee only	2.45%
Employee +1	2.75%
Family	3.05%
Eligible part-time teachers	
Employee only	5.9%
Employee +1	6.5%
Family	7.1%
Eligible non-union employees	
Employee only	3.7%
Employee +1	4.0%
Family	5.0%
UniteHere Local 1	
Employee only	3.0%
Employee +1	3.25%
Family	3.5%
SEIU Local 1	
Employee only	2.2%
Employee +1	2.5%
Family	2.8%

PPO with HSA

How much you pay per-paycheck	
CTU	
Employee only	0.75%
Employee +1	1.75%
Family	2.65%
SEIU Local 73, Teamsters Local 700, Electrical Workers 134	
Employee only	0.25%
Employee +1	1.25%
Family	2.15%
Eligible part-time teachers	
Employee only	1.50%
Employee +1	3.25%
Family	5.30%
Eligible non-union employees	
Employee only	2.8%
Employee +1	3.0%
Family	3.8%
UniteHere Local 1	
Employee only	0.0%
Employee +1	1.0%
Family	2.0%
SEIU Local 1	
Employee only	0.0%
Employee +1	1.0%
Family	1.9%

Questions? Email healthandbenefits@cps.edu or call 773-553-HR4U.

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Physical Health

Good to know

PPO participants will not incur out-of-pocket expenses when receiving physical and occupational therapy at an Athletico clinic. Deductibles and visit limits still apply.

Medical Plans Compared

		Blue Advantage HMO	Traditional PPO		PPO with HSA	
HSA Contribution (Single/Family)		N/A	N/A	N/A	Single: $600/Family: $2,000	
		In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	Individual	No Deductible	$600	$1,200	$2,000	$4,000
	Individual+1	No Deductible	$1,800	$3,600	$4,000	$8,000
	Family	No Deductible	$1,800	$3,600	$4,000	$8,000
Out-of-Pocket Maximum	Individual	$1,500	$2,700	$5,400	$4,000	$8,000
	Individual +1	$3,000	$5,200	$10,800	$8,000	$16,000
	Family	$3,000	$5,200	$10,800	$8,000	$16,000
Doctor's Visit	General office visits	100% covered $30 Regular copay $45 Specialist copay $30 Urgent copay	80% covered $25 Regular copay $40 Specialist copay $25 Urgent copay	50% covered $25 Regular copay $40 Specialist copay $25 Urgent copay	80% covered after deductible	50% covered after deductible
	Wellness/preventive care	100% covered (no copay)	100% covered (no copay)		100% covered (no copay, no deductible)	
Telemedicine (Virtual Visits)		100% covered $30 Regular copay $45 Specialist copay $30 Urgent copay	$25 copay	Not covered	80% covered after deductible	Not covered
Inpatient hospital services	Hospital (semi-private) room and board	$275 copay per admission, then 100% covered	$100 deductible per admission, then 80% covered after deductible	$100 deductible per admission, then 50% covered after deductible	80% covered after deductible	50% covered after deductible
	Doctor's visits (including specialists), x-rays, drugs, surgeon fees and anesthesiologists	100% covered (no copay)	Included in in-patient hospitalization		Included in in-patient hospitalization	
Outpatient hospital care (includes surgery)		$225 copay per visit, then 100% covered	80% covered after deductible	50% covered after deductible	80% covered after deductible	50% covered after deductible
Maternity	Prenatal/postnatal	$30 copay	100% after $40 copay	50% covered after deductible	80% covered after deductible	50% covered after deductible
	Hospital coverage (mother and newborn)	$275 copay, then 100% covered	80% covered after deductible	50% covered after deductible	80% covered after deductible	50% covered after deductible

Questions? Email healthandbenefits@cps.edu or call 773-553-HR4U.

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Physical Health

Want to find more plan information?

Visit bcbsil.com to find information about your claims, request an ID card, and access more information.

Medical Plans Compared

		Blue Advantage HMO	Traditional PPO		PPO with HSA	
		In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered emergency care	Emergency care (if deemed an emergency)	$200 copay per visit for in- and out-of-network providers, then 100% covered	$200 copay, then 100% covered		80% covered after deductible	
	Ambulance	100% covered. Ground Transportation only.	100% covered after deductible		100% covered after deductible	
Behavioral/ Mental Health (unlimited visits)	Inpatient	$275 copay then 100% covered	80% covered after deductible	50% covered after deductible	100% covered after deductible	80% covered after deductible
	Outpatient	$20 copay then 100% covered	$25 copay, then 100% covered	$25 copay, then 80% covered	100% covered after deductible	80% covered after deductible
Therapy	Physical, occupational and speech therapy for restoration of function approved by doctor	100% covered for the number of visits which, if approved by a doctor, up to 60 visits per specialty (physical therapy, occupational therapy, speech therapy)	$30 copay, then 100% covered after deductible, up to 60 visits per specialty (physical therapy, occupational therapy, speech therapy)	80% covered after deductible, up to 60 visits per specialty (physical therapy, occupational therapy, speech therapy)	$30 copay, then 100% covered after deductible Limited to 60 visits per specialty (physical therapy, occupational therapy, speech therapy)	80% covered after deductible Limited to 60 visits per specialty (physical therapy, occupational therapy, speech therapy)
	Chiropractic care	100% covered after $45 copay per visit. Unlimited visits for chiropractic therapy.	$30 copay, then 100% covered after deductible. Unlimited visits for chiropractic therapy.	80% covered after deductible. Unlimited visits for chiropractic therapy.	$30 copay, then 100% covered after deductible. Unlimited visits for chiropractic therapy.	$30 copay, then 80% covered after deductible. Unlimited visits for chiropractic therapy.
Care in skilled nursing facility (up to 120 days/year if medically necessary)		100% covered 60 calendar day limit	80% covered after deductible	50% covered after deductible	80% covered after deductible	50% covered after deductible
Prosthetic devices and medical equipment		100% covered	80% covered after deductible	50% covered after deductible	80% covered after deductible	50% covered after deductible
Pharmacy (See page 22 for more information)					80% covered after deductible	50% covered after deductible
		Review full plan details here Review plan SPD here	Review full plan details here Review plan SPD here		Review full plan details here Review plan SPD here	

Physical Health

Prescription Drugs

Prescription drug coverage is included with your medical plan.

You have three convenient ways to purchase your prescription medications through CVS/Caremark:

1. At a participating pharmacy
2. By mail order
3. At a non-participating pharmacy.

However, with a network of 62,000 participating pharmacies, purchasing your medications from an in-network pharmacy should be easy and will save you significant money!

Find a Caremark participating retail pharmacy

Register or login to your account at 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. To register, have your benefits ID card handy.

You can also search your formulary to find covered medications and access tools that can help you save money and manage your prescription benefit.

When to use a retail vs. a mail order pharmacy

Retail: 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.

Mail order: 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.

Questions about vaccines and immunizations? Read the CPS Rx and Vaccine Coverage Overview for more information.

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Physical Health

A note about your deductible

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

Prescription Drug Costs

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 through an appeal process or the employee's doctor completes the Caremark prior authorization process.

Blue Advantage HMO

Retail	Mail Order
$10 for each generic medicine after deductible.	$20 for each generic medicine after deductible.
$40 for each brand-name medicine on the drug list after deductible.	$90 for each brand-name medicine on the drug list after deductible.
$55 for each brand-name medicine not on the drug list after deductible.	$120 for each brand-name medicine not on the drug list after deductible.
$95 for specialty medicine* after deductible.	$200 for specialty medicine* after deductible.

Traditional PPO

Retail	Mail Order
$10 for each generic medicine after deductible.	$20 for each generic medicine after deductible.
$40 for each brand-name medicine on the drug list after deductible.	$90 for each brand-name medicine on the drug list after deductible.
$55 for each brand-name medicine not on the drug list after deductible.	$120 for each brand-name medicine not on the drug list after deductible.
$95 for specialty medicine* after deductible.	$200 for specialty medicine* after deductible.

PPO with HSA

Retail	Mail Order
80% covered after medical deductible is satisfied.	80% covered after medical deductible is satisfied.

Follow the formulary!

Find out which drugs are listed on the CVS Caremark forumlary here.

*CVS/Caremark pharmacy staff continually reviews medicines, products and prices for your plan sponsor. This could affect certain specialty prescription drugs. Call CVS Caremark Specialty Pharmacy toll-free at (800) 237-2767 if you have questions.

Questions? Email healthandbenefits@cps.edu or call 773-553-HR4U.

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Physical Health

Prescription Drugs – New Features, Better Care

The Diabetic Meter Program
This value-added program — available to those enrolled for coverage in the Blue Advantage HMO medical plan — will provide eligible members with a blood glucose meter at no out-of-pocket cost. To qualify for this program, you must:

- Be enrolled in the prescription benefit plan
- Have diabetes
- Have a valid prescription for blood glucose test strips. If you don't already have a prescription you can request one at caremark.com/managingdiabetes.

Additional requirements or limitations may apply. Meters will be shipped to members within 7 to 10 days of order.

Caremark Good Rx Cost Saver
This features makes sure members get the lowest possible cost for medications covered under their plan. All you have to do is present your CVS Caremark member ID card when you pick up your prescriptions. CVS will manage the rest for you by automatically applying the lowest available discount price.

Teledoc Transform Diabetes Care and Hypertension Program
This program offers members with:

- Diabetes — an advanced blood glucose meter, strips and lancets at no cost.
- Hypertension — instant tips as well as real-time support to help manage their blood pressure.

Physical Health

Prescription Drugs – Non-Participating Pharmacies

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 price when you fill the prescription.** 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

Find a Caremark participating retail pharmacy

Register or login to your account at 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. To register, have your benefits ID card handy.

You can also search your formulary to find covered medications and access tools that can help you save money and manage your prescription benefit.

Continued on next page

Physical Health

What is a specialty drug?

Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis.

Prescription Drugs – Save Money on Specialty Drugs with PrudentRx

CPS strives to help our plan members receive prescription drugs at the lowest possible price. Plan members using most specialty medications will be enrolled in a specialty drug discount program through CVS Caremark called PrudentRx.

This program is part of your benefit plan and will give you a $0 copay on your specialty prescription medications. PrudentRx will contact you if your specialty prescription is included in the program.

You will still fill your specialty prescriptions through your CVS Caremark benefit plan.

Enroll in PrudentRx

Enrollment is easy and takes just a few minutes with the PrudentRx representative, who will help you through the process.

Participation is a required part of the process of filling your specialty prescriptions with CVS Caremark, so please be sure to work with the PrudentRx team to be enrolled if you are contacted.

Call (866) 409-8523 or visit caremark.com to enroll or learn more.

Physical Health

Pre-Authorization for Services

Your health insurance may require pre-authorization (sometimes called prior authorization, prior approval or pre-certification) for certain services before you receive them.

If you are enrolled in either PPO plan, you may require pre-authorization from BCBSIL 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
- Hospice: inpatient and home.
- Home nursing visits.
- Private duty nursing.
- Durable medical equipment and supplies
- 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).

To request a pre-authorization, call BCBSIL at (800) 572-3089 between 8:00 a.m.–6:00 p.m. Monday–Friday.

When you should call:

- You must call at least seven days in advance for most services requiring pre-authorization.
- You must call within two business days after emergency treatment or inpatient admissions.
- All pregnancies must be pre-authorized twice, during the first three months or when the pregnancy is confirmed (if later) and again within two business days after admission for delivery (not including weekends).

If you 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.

See the Summary Plan Documents (SPDs) for a full list of services requiring pre-authorization and additional information:

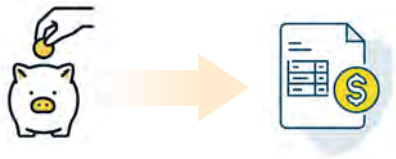
- BCBS Blue Advantage HMO SPD
- BCBS PPO SPD

Physical Health

PPO with HSA plan participants only

Health Savings Account – A Powerful Way to Save and Spend

A Health Savings Account (HSA) is a personal savings account that allows you to make pre-tax contributions and then use the funds to pay for eligible out-of-pocket health expenses (medical, dental, vision) with pre-tax dollars.



You are eligible to contribute to an HSA if:

- ✓ You enroll in the PPO with HSA plan;
- ✓ You are not covered under another health plan, including Medicare, unless the plan is also a HDHP;
- ✓ You and your spouse don't have a Health Care Flexible Spending Account;
- ✓ You cannot be claimed as a dependent on someone else's tax return

HSAs offer a triple-tax advantage—a powerful combination that can help you save up to 30 percent on taxes:

1. Your contributions are deducted pre-tax from your paycheck.
2. You can invest the money in your account once you reach a minimum balance and earnings are tax-free.
3. Withdrawals for qualified medical expenses are all tax-free.

The money in your HSA is yours to keep—it goes with you wherever you go and carries over from year to year.

Note: 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. Employer contributions will be deposited only after the account is opened. Retroactive deposits will not be made. Monthly maintenance fees may be charged depending on the balance in the account. Contact HSA Bank for more information on monthly fees. 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.

Continued on next page

Physical Health

Health Savings Account – How to Contribute

Contributing to an HSA is easy
You may elect to make HSA contributions at any time throughout the year, however, you must elect the PPO with HSA plan during enrollment, as a new hire, or if you experience a qualifying life event in order to be eligible.

- You can contribute up to $4,300/individual and $8,550/family to your HSA in 2025.
- If you are age 55 or older, you can also make a $1,000 "catch-up" contribution.

Once you have a minimum balance in your HSA, you can open an investment account. There are a variety of mutual funds to choose from. There are also no transfer or trading fees and no minimum investment amount for a trade request.

Use the HSA Savings Calculation Tool to discover the savings opportunity and tax advantages associated with an HSA at hsabank.com.

CPS will contribute to your HSA, too!

- $600/single coverage
- 1,500/employee+1 coverage
- $2,000/family coverage.

Funds will be paid incrementally per pay period. Employer contributions will be pro-rated based on the beginning date of enrollment in the PPO with HSA plan and after you complete the process to open the HSA account.

School-based employees will receive a bulk contribution for the summer break after paychecks begin for the new school year. Employees enrolled in the HSA plan may not reach the full contribution based on their start date.

Employees must open their account with HSA Bank in order to receive funds. Any employee without an active account will not receive any contributions.

Physical Health

Select the DELTACARE Network when searching for an in-network dentist on DeltaDental's website.

Dental Plans

We offer two dental plan options for you to choose from through Delta Dental.

Delta Dental DHMO

How much you pay per-paycheck		
	20 pay periods	26 pay periods
Employee only	$0 (CPS covers the cost)	
Employee +1		
Family		

If you select this plan, coverage will cost you nothing! CPS covers the full dental contribution deduction for all coverage levels. And, you get to choose your own dentist from Delta Dental's vast network. Just use a facility ID from the provider network sponsored by Delta Dental, which can be found at deltadentalil.com.

Delta Dental PPO

How much you pay per-paycheck		
	20 pay periods	26 pay periods
Employee only	$0 (CPS covers the cost)	$0 (CPS covers the cost)
Employee +1	$12.62	$9.71
Family	$26.73	$20.56

If you choose this plan, CPS will cover the cost of coverage only for employees. You will pay an additional cost for +1 or family coverage. With this 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.

		Delta Dental HMO	Delta Dental PPO	
	Services	In-Network Only	In-Network	Out-of-Network
	Preventive/Diagnostic	Covered 100%	Covered 100%	Covered 100%
	Basic	75–85%	Covered 80%	Covered 80%
	Major	65–70%	50% of PPO rate	50% of PPO rate
Individual maximums	Deductible	None	None	$100 annually
	Benefit Limit	None	$2,000 annually	$2,000 annually
	Orthodontics	50% coinsurance to lifetime maximum of $2,000 for adults & dependents up to age 26.	50% coinsurance to lifetime maximum of $2,000 for adults & dependents up to age 26.	

Physical Health

Vision plans

We offer you two choices for your vision coverage through EyeMed Vision Care.

Basic Vision Plan

How much you pay per-paycheck	
Employee only	$0 (CPS covers the cost)
Employee +1	$0 (CPS covers the cost)
Family	$0 (CPS covers the cost)

Employees and eligible dependents enrolled in BCBSIL medical plans can access basic vision coverage through EyeMed Vision Care with no additional premium contribution.

The basic vision plan provides one eye exam per year for a $15 copay. In addition, you will receive discounts on eyewear.

Enhanced Vision Plan

How much you pay per-paycheck (20 pay periods)	
Employee only	$4.44
Employee +1	$6.48
Family	$11.63

How much you pay per-paycheck (26 pay periods)	
Employee only	$3.42
Employee +1	$4.99
Family	$8.95

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 in-network and retail providers to find the one that best fits your needs and schedule.

Continued on next page

Physical Health

Vision plans

We offer you two choices for your vision coverage through EyeMed Vision Care.

		Basic Vision Plan	Enhanced Vision Plan
Eye exam	Member cost	$15 copay	$15 copay
	Frequency	12 months	12 months
Frames	Member cost	Discounts only	$0 copay
	Frequency	Unlimited	12 months
Standard lenses and contacts	Member cost	Copay range $50-$135 (Discounts on contacts)	$25 copay
	Frequency	Unlimited	Both 12 months
Lens options	Member cost	Standard progressive: $135 Anti-reflective standard: $45 Polycarbonate: $40 Scratch, Tint, UV: $15	Standard progressive:$90 Premium progressive: $110, $120, $135, $200 Anti-reflective standard: $45 Premium anti-reflective coating: $57, $68, $85 Polycarbonate:$35 Scratch: $0 Tint: $10 UV: $0 Photochromic:$0
	Frequency	Unlimited	Every 12 months

Continued on next page

Physical Health

Vision Plans – Enhanced Plan Benefits

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 with $0 copay once every calendar year

Standard lenses once every calendar year

- Cost: Single, bifocal, trifocal and lenticular: $25 copay.
- 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 copay, $175 allowance, 15% off balance over $175
- Disposable: $0 copay, $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.

Physical Health

Behavioral Health Resources

Get the help you need to manage life's demands and addiction. As a CPS employee, you can access counseling and substance abuse recovery services to help you effectively deal with stressful and challenging situations, such as:

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

If you are enrolled in the PPO or PPO with HSA medical plan, contact BCBSIL to access services. Provider listings are subject to change. Find a provider at bcbsil.com or call (800) 851-7498.

If you are in the Blue Advantage HMO plan, contact your primary care physician to receive services.

All calls and services are strictly confidential.

Physical Health

Wellness Program

The BCBS wellness program, **Well onTarget**, 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.

Access Well onTarget 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.

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 longterm 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.

Participation is highly encouraged. Take stock of yourself and your health. This program will help you do that.

Financial Protection

In this section:

- Flexible Spending Accounts (FSAs)
- Short-Term Disability
- Long-Term Disability
- Life Insurance and AD&D Coverage
- Critical Illness Insurance
- Accident Insurance
- Hospital Indemnity Insurance
- Supplemental Retirement
- College Savings Program

View All Benefits

Financial Wellness

Flexible Spending Accounts (FSAs)

CPS offers two types of Flexible Spending Accounts (FSAs), administered through through HSA Bank. These accounts work in a similar way to a savings account, but they allow you set aside pre-tax funds from your paycheck each pay period to pay for eligible expenses, thereby reducing your taxable income. It is important to plan your contributions carefully — the IRS "use it or lose it" rule applies to FSAs and any unused funds will be forfeited.

Healthcare Flexible Spending Account (FSA)

With a Healthcare FSA, you can use the funds to pay for eligible medical, dental, and vision expenses such as deductibles, coinsurance, copays and over-the- counter medications for yourself and your eligible dependents.

You can enroll in the Healthcare FSA if you enroll in the HMO or traditional PPO medical plan, are not enrolled in any other high deductible plan, or do not elect medical coverage.

You can contribute up to $3,200* to a Healthcare FSA.

Dependent (Day) Care Flexible Spending Account (FSA)

With a Dependent (Day) Care FSA, you can pay for qualified dependent care expenses such as daycare and after school programs for children up to the age of 13, or older children who are mentally or physically incapable of caring for themselves.

In addition, you can use these funds for programs that care for eligible family members who are elderly or otherwise dependent.

You can contribute up to $5,000* ($2,500 if married and filing separate tax returns) to a Dependent (Day) Care FSA.

Your FSA elections will be in effect from January 1 through December 31. Claims for expenses incurred by December 31, 2025, must be submitted by March 31, 2026. 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.

*2024 contribution limits. The IRS has not yet released the 2025 contribution limits.

Continued on next page

Financial Wellness

Flexible Spending Accounts (FSA)

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

1. Point of Sale
For your copayments and prescription drugs, you may use a debit card issued by HSA Bank. to access your account.

2. Paper Submission/Online Portal/Mobile App
Log into your account and submit a claim on the portal. Healthcare FSA forms are available at HSABank.com.

You may submit a paper/online submission at any time after you have accumulated eligible reimbursable expenses. Dependent care flexible spending is reimbursed based on contributions. If you have contributed $1,000 and your claim is $2,000, it will pay out the $1,000. As contributions are made, it will pay the remaining amount.

Account Balances
View your FSA account balances online at HSABank.com. You will be required to create a personalized online account to access this information. You also may retrieve balance information by calling (877) 837-5017.

Learn more about FSA account details at HSABank.com.

A note on eligible expenses

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 HSA Bank debit card or that you submit for reimbursement are eligible for reimbursement under IRS rules.

Eligible items can be found at HSABank.com or IRS.gov.

Financial Wellness

Short-Term Disability

This benefit is designed to replace income lost during periods of disability resulting from a non-occupational injury, illness, or pregnancy.

CPS automatically provides employer-paid Short-Term Disability benefits for all eligible employees — no contributions or enrollment forms are required!

Who is eligible?
All CPS employees who are members of an eligible class are covered under short-term disability. These include:

- Collectively bargained employees; or
- Non-union employees (Employees who are not members of a bargaining class)
  - Who are full-time benefits eligible employees under Board rules or policies; **AND**
  - Who are part-time teachers assigned to a position number and benefits eligible employee as a member of the Chicago Teachers Union; and
  - 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.

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.

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.

Continued on next page

Financial Wellness

Short-Term Disability

Income replacement

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.

Submitting a Request

1. 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.
2. Apply online: cps.edu/staff then click on the link for HR4U. Download required forms and submit within 15 calendar days.
3. Absence and Disability Department will review medical certification upon receipt and send a determination letter to you and your supervisor within 4 business days.
4. Ongoing communication with your supervisor and/or Absence and Disability Department may be required throughout the duration of your leave of absence.

Many stipulations and additional information on your Short-Term Disability benefits can be found in the full plan document.

Financial Wellness

Long-Term Disability

In addition to the CPS-provided Short-Term Disability benefit, employees have the option of purchasing Voluntary Long-Term Disability Insurance through The Standard. 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 based on the waiting period -- the amount of time you are unable to perform your job duties before you begin to receive a benefit:

- 90-day waiting period
- 180-day waiting period

Both plans provide a monthly benefit of 60% of your monthly earnings, reduced by other income you may receive.

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 within 31 days of becoming eligible for LTD, 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.

You pay the full premium for LTD coverage. Premiums are determined by age and annual salary.

How much you pay per-paycheck

See Long-Term Disability rates here.

Get screened. Earn $50.

You and your covered dependents will receive a $50 cash benefit each calendar year when completing one of many eligible health screenings.

Financial Wellness

Life Insurance and Accidental Death & Dismemberment (AD&D) Coverage

CPS provides Basic Life Insurance coverage of $25,000 for each eligible employee. CPS also offers the following Supplemental Life Insurance coverage options through The Standard for those who would like extra protection:

- **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 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.

Newly hired employees who enroll within 31 days of becoming 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.

If an employee has been eligible for Life Insurance, but not participating in the plan, and later decides to add coverage, Evidence of Insurability (EOI) will be required. In addition, 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.

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.

Financial Wellness

Critical Illness Insurance

Critical Illness Insurance from The Standard helps cover out-of-pocket expenses that come with being very ill. A variety of illnesses are covered, including heart attack, cancer, stroke, and more.

It pays you a lump-sum cash benefit for eligible expenses. You can use the funds in any way you like, including:

- Medical deductibles
- Childcare costs
- Housecleaning
- Groceries
- Utilities
- and more

You pay the full cost of critical illness insurance and it is deducted from your paycheck on a post-tax basis.

Visit CPS.edu/HR4U for more information and to enroll.

Get screened. Earn $50.

You and your covered dependents will receive a $50 cash benefit each calendar year when completing one of many eligible health screenings.

How much you pay per-paycheck

See Critical Illness Insurance rates here.

Financial Wellness

Accident Insurance

Accident Insurance from The Standard helps pay out-of-pocket costs following a covered accident.

This coverage provides a cash benefit to the insured to be used in any way they see fit. Covered individuals can also receive an extra 25% of total benefits for injuries sustained 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)

Visit CPS.edu/HR4U for more information and to enroll.

How much you pay per-paycheck

See Accident Insurance rates here.

Financial Wellness

Hospital Indemnity Insurance

Hospital stays can be expensive, even with medical insurance. Hospital Indemnity Insurance from The Standard helps cover out-of-pocket expenses that come with a hospital stay. This benefit pays you a lump-sum cash benefit and you can use the funds in any way you like, including:

- Medical deductibles
- Childcare costs
- Housecleaning
- Groceries
- Utilities
- and more

You pay the full cost of hospital indemnity insurance and it is deducted from your paycheck on a post-tax basis. If you are hospitalized for more than 30 days, your premium is waived.

Visit CPS.edu/HR4U for more information and to enroll.

How much you pay per-paycheck

See Hospital Indemnity Insurance rates here (page 2).

Get screened. Earn $50.

You and your covered dependents will receive a $50 cash benefit each calendar year when completing one of many eligible health screenings.

Financial Wellness

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 Corebridge Financial.

All employees may enroll with Corebridge Financial. View the Enrollment Guide to learn more.

	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	$23,000*	$23,000*
Contribution limits if you are over age 50	Additional "catch-up" contribution of $7,500* for 2025 is permitted, for a total limit of $30,500. 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 Corebridge Financial, the record keeper and fund provider, to determine eligibility.	Additional "catch-up" contribution of $7,500* for 2025 is permitted, for a total limit of $30,500*

*IRS limits subject to change

Continued on next page

Financial Wellness

Supplemental Retirement

Unused Sick Day/403(b) Contributions
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

- 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.
- 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.
- The unused sick day contribution will be sent within 75 days from the date of the notification letter.

Contribution for a Participant Not Currently Enrolled

- 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.
- 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

- The maximum contribution is $80,000.
- If a retired employee has more than $80,000 in accumulated sick pay, the excess will be paid directly to the retired employee.
- The maximum annual contribution limit for 2025 is $70,000. If the retired employee is currently contributing to a 403(b) plan, the amount will be subtracted from the $70,000.

To begin saving for your retirement through payroll deduction, visit corebridgefinancial.com/rs/cps or call (800) 448-2542.

Financial Wellness

College Savings Program

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 brightstartsavings.com.

Work/Life Harmony

In this section:

- The Employee Assistance Program (EAP)
- Paid Time Off
- Maintaining Benefits During a Leave of Absence
- What happens to my benefits when I leave?

View All Benefits

Work/Life Balance

The Employee Assistance Program (EAP)

CPS offers an Employee Assistance Program (EAP) through ComPsych GuidanceResources that can help you and your household members with a wide range of issues , such as:

- Job stress
- Family or relationship concerns
- Depression or anxiety
- Substance abuse or misuse
- Legal and financial issues
- and more

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.

You can reach the EAP at guidanceresources.com or download the GuidanceResources Now app (Web ID: BCBSILEAP).

You can also reach the EAP by phone, 24/7/365 for a consultation at (800) 890-1213.

Work/Life Balance

Paid Time Off

CPS understands the need to take time away from work for illness, personal reasons, and vacation. We offer a generous paid time off package in addition to regularly scheduled annual paid holidays. These include:

Sick days
You will have one sick day for every scheduled full month of regular work, maintained in your Sick Day Bank.

Personal Business Days
You will receive three personal days each year. These will be prorated for new employees based on their start date.

Vacation Days
Teachers and employees employed for less than 52 weeks (including appointed and temporarily assigned teachers) receive up to ten days of paid vacation each yea -- five during the Winter Recess and five during the Spring Recess as designated in the academic calendar. New teachers or employees with employment periods less than 52 weeks per year are eligible for three paid vacation days for winter recess. Vacation days do not accumulate and must be used .

Annual Holidays

- Labor Day
- Indigenous Peoples' Day
- Veterans Day
- Thanksgiving Holiday
- Martin Luther King Day
- Presidents' Day
- Memorial Day

Work/Life Balance

Maintaining Benefits During a Leave of Absence

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 CPS via the Benefits Billing vendor.

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 or via the ePay website.

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. You may now pay your benefit billing statement online through ePay. A QR code is available on the benefit billing statement for your use or you can access the site with this link. You may still make payments directly to the benefits billing lockbox at the address indicated on your benefit billing 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.

If you lose benefits while on leave

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.

Continued on next page

Work/Life Balance

Maintaining Benefits During a Leave of Absence

Non-Sufficient Funds (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.

Non-Payment
If your benefits are terminated due to no-payment, you are not eligible to receive COBRA.

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.

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.

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Work/Life Balance

Maintaining Benefits During a Leave of Absence

How to reinstate benefits upon return to work:

1. Notify the Health and Benefits team by email them at healthandbenefits@cps.edu within 31 days 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

ePay Link

Work/Life Balance

Check out this video on how to smoothly transition and prepare for your last day at CPS.

What happens to my benefits if I leave CPS?

The following chart explains what happens with your benefits when you leave CPS.

Medical	Your coverage ends on the last day of the month in which you terminate.
Dental	
Vision	
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)	Your account is yours to keep and you may use any available funds.
Short-Term Disability (STD)	Your coverage ends the same day as your last day worked.
Long-Term Disability (LTD)	
Life Insurance and Accidental Death & Dismemberment (AD&D)	Your coverage ends on the last day of the month in which you terminate.
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.
For Retirees	Your retirement date is the last date CPS pays primary. For any services provided after your retirement date, Medicare is primary if you and/or your spouse are Medicare eligible.

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Work/Life Balance

COBRA benefits are administered by Payflex, which may be reached at (800) 359-3921.

What happens to my benefits if I leave CPS?

Continuation of Benefits

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. You pay the full cost of these benefits. Note: If you are not enrolled in a medical or dental plan on the day your employment terminates or your work hours are reduced, you are not able to elect coverage.

Covered spouses may also continue medical, dental and vision coverage due to:

- Death
- Divorce
- Legal separation

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
Termination or layoff	You, spouse, and dependents	18 months*
Reduction in hours		
Divorce or legal separation	Spouse and dependents	36 months
Dependents have reached limiting age	Dependents	
You choose Medicare as primary coverage	Non-Medicare eligible spouse and dependents	
Death	Spouse and dependents	

*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.

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

Benefit	Provider/Group Number	Phone Number	Group Number	Address	Website/Email
Have a question about your benefits?	Health and Benefits Team	(773) 553-HR4U			healthandbenefits@cps.edu
Medical	Blue Cross Blue Shield (Blue Advantage HMO)	(866) 248-3092	B12709	P.O.Box 1364 Chicago, IL 60690	bcbsil.com/members
Medical	Blue Cross Blue Shield (PPO)	(800) 331-8032	P12709	P.O.Box 2352 Chicago, IL 60690	bcbsil.com/members
Medical	Blue Cross Blue Shield (PPO with HSA)	(800) 331-8032	191904	P.O.Box 2352 Chicago, IL 60690	bcbsil.com/members
Prescription Drug	CVS Caremark	(866) 409-8523	CPSRX	P.O.Box 686005 San Antonio, TX 78268-6005	caremark.com
Health Savings Account(HSA)	HSA Bank	(855) 731-5220		605 N. 8th St. Ste 320 Sheboygan, WI 53081	hsabank.com
Dental	Delta Dental	(800) 323-1743	10083	P.O.Box 5402 Lisle, IL 60532-5402	deltadentalil.com
Vision	EyeMed Vision Care	(855) 347-6900		4000 Luxottica Place Mason, Ohio 45040	eyemed.com
Flexible Spending Accounts (FSAs)	HSA Bank	(855) 731-5220		605 N. 8th St. Ste 320 Sheboygan, WI 53081	hsabank.com
Life Insurance and Accidental Death & Dismemberment	The Standard	(833) 960-1238	758951		standard.com
Disability Insurance	The Standard	(833) 960-1238			standard.com
Accident Insurance	The Standard	(833) 960-1238			standard.com
Critical Illness Insurance	The Standard	(833) 960-1238			standard.com
College Savings Program	BrightStart	(800) 655-4853			brightstartsavings.com
Retirement	Corebridge Financial	(800) 448-2542			corebridgefinancial.com/rs/cps
Retirement Manager		(866) 294-7950			corebridgefinancial.com/rs/cps
Employee Assistance Program (EAP)	ComPsych Guidance Resources	(800) 890-1213			guidanceresources.com

The information in this handbook is effective January 1, 2025, 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.–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