2023 Benefits

Explore Your Benefits!

ALA American Library Association

01/01/2023 - 12/31/2023

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At the American Library Association, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

Here’s some important information you should know.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs) found on the ALA support site. The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide on page 34.

The benefits in this summary are effective
01/01/2023 through 12/31/2023

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Total Compensation Statement

At the American Library Association, we appreciate the invaluable contributions made by our employees, ALA's greatest asset. Because ALA's success, as an association, depends on employees, ALA tries to provide the most comprehensive and competitive compensation and benefits program that will help protect employees' personal and financial well-being. While benefit costs have increased enormously in recent years, ALA is still committed to keep benefits competitive.

See your personalized ***Total Compensation Statement*** to understand the full extent of ALA's investment in you. Your total compensation is the combination of your pay and benefits package, it will help you understand the full extent of ALA's investment in you.

You can find your total compensation information in ***UKG,*** from the home page go to ***Menu > Myself > Pay > Total Compensation***. Your ***Total Compensation Statement*** will keep you informed of ALA's contributions to the benefit plans you select and will be updated after each payday.

See Human Resources with any questions about your Total Compensation Statement.

Total Compensation

Information

- We are pleased to present your personalized Total Compensation Statement that provides a comprehensive snapshot of all benefits paid by ALA. Your statement provides you with the full value of rewards you earn beyond just your base salary. ALA is committed to taking care of you and ensuring that you are competitively rewarded for your contributions and performance.

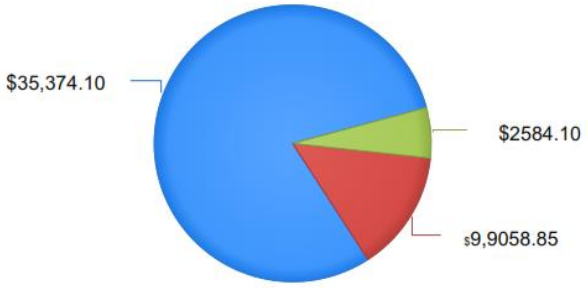
Year 2020 **Total Compensation $47,016.99**

Earnings Paid	**$35,374.04**
Earning	**Amount**
Group Term Life	$135.30
Regular Pay Salary	$35,238.74

Employer Paid Benefits	**$9,058.85**
Deduction	**Amount**
AD&D	$10.20
Basic Life Insurance	$ 95.72
Dental -Guardian High	$264.29
LTD	$102.90
Medical BCBS PPO	$6,311.80
Retirement Annuity 3% Match	$ 974.53
Retirement Annuity 4% ALA Basic Contrib	$1,299.41

Employer Paid Taxes	**$2584.10**
Tax	**Amount**
Employer Medicare	$453.38
Social Security Employer Tax	$2,130.72

(Year 2020) Total Compensation: $47,016.99



Are You Eligible For Benefits?

When you can enroll

You're eligible for benefits if you are a full-time or part time employee in a regular position (at least a .5 fte) working at least 17.5 hours per week (temporary employees and interns are not eligible).

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the 1st of the month following 30 days of employment as long as you enroll within 10 days of your hire date. If you miss the enrollment deadline, the next time you can enroll will be open enrollment (the one time each year that you can make changes to your benefits for any reason).

Your eligible dependents

- Legally married spouse
- Civil union partner
- Domestic partner (see requirements and tax treatment on page 35)
- Natural, adopted, or stepchildren up to age 26 (or 30 if honorably discharged from military)
- Tax dependents over age 26 who are Social Security disabled
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Family members such as parents, grandparents and siblings who are not your tax dependents as described above are not eligible for coverage.

Qualifying events, changing your benefits

Outside of open enrollment, you may be able to add or remove dependents or change benefit options if you have a qualifying event and submit your change within 30 days of the event. Eligible qualifying life events include:

- change in legal marital or domestic partner status (see full details about Domestic Pattern Coverage).
- change in number of dependents or dependent eligibility status
- change in employment status that affects eligibility for you, your spouse/domestic partner, or dependent child(ren)
- change in residence that affects access to network providers
- change in your health coverage or your spouse/domestic partner's coverage due to your spouse/domestic partner's employment
- change in an individual's eligibility for Medicare or Medicaid
- court order requiring coverage for your child
- "special enrollment" event under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

How to Enroll

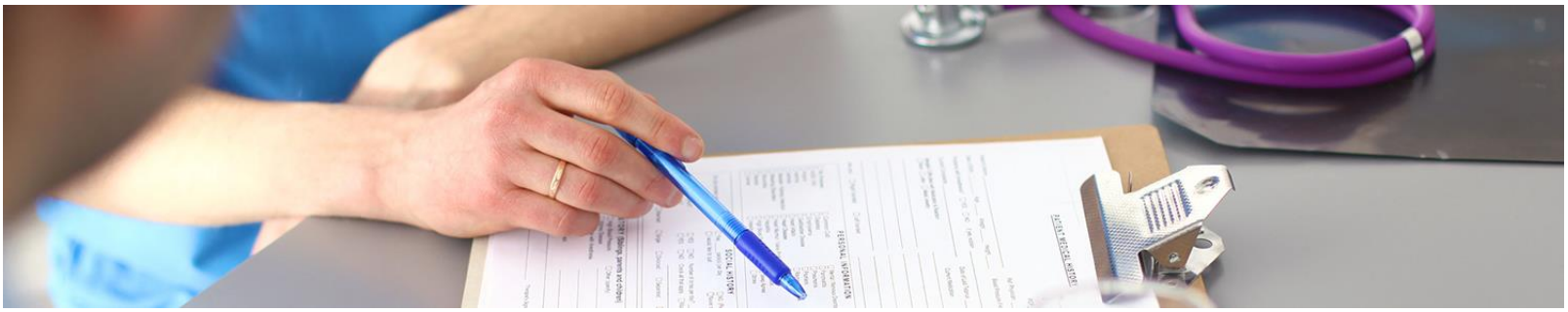
Here are some tips to help you get started.

Before you enroll

- Collect the date of birth, Social Security Number (SSN), and address for each dependent and/or beneficiary you wish to include.
- Consider your needs and the needs of your eligible dependents.
- Review any benefits offered through your spouse's/domestic partner's employer to avoid costly duplicate coverage.
- Carefully review the information in this benefits summary and other enrollment materials.

When and how to enroll

- **New Hires:** Please study the information about each plan carefully, then, promptly complete the enrollment forms provided so that you can begin to enjoy the features of your benefits program as soon as they become effective.
- Remember, New Hire coverage begins on the 1st of the month following 30 days of employment as long as you enroll within 10 days of becoming eligible. If you are enrolling due to a Qualifying Life event, you must submit your change within 30 days of the event.
- **Open Enrollment:** First review your current benefit elections in UKG under "Myself" on the "Benefits" tab, where you will see your current benefits listed. Consider the various options and make your choices for 2023. We will use UKG from November 9th to 15th, 2022. All forms are due by November 15th, 2022, to Grisela Rodriguez in Human Resources. You will be able to elect from the plans available to you and your qualified dependents for 2023. Changes to life and disability elections from the prior year will require additional forms; UKG will prompt you when you need to complete an additional form based on your elections.
- Remember, choices you make at Open Enrollment will be effective until the next Open Enrollment period for 2024 unless you have a qualifying event or change in status during the year.
- If you need help, please contact Grisela Rodriguez at 312-280-2467 or grodriguez@ala.org



Choosing a Medical Plan

Choosing a new medical plan? Check out these tips first.

- CHECK THE NETWORK– Do you prefer specific doctors or hospitals? Visit the plan's website to find out if they are in-network. If not, you'll pay a bigger share of the cost. More information on finding a doctor can be found on page 10.
- EVALUATE YOUR NEEDS– Do you... have frequent doctor or urgent care visits? ...get ongoing tests? ...take medications? ...have surgery planned? Compare these costs under each plan.
- THE BOTTOM LINE– How much is the premium? Is there a deductible? Can you offset expenses with a tax-free account such as an FSA? Each of these factors can affect your true cost of healthcare.
- WORDS TO KNOW– Understanding these terms will help you understand and compare plans.

DEDUCTIBLE

The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

COINSURANCE

After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.

COPAY

A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.

OUT-OF-POCKET MAXIMUM

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.

IN & OUT-OF-NETWORK

In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

BALANCE BILLING

In-network providers are not allowed to bill more than the plan's allowable charge, but out-of-network providers are. For example, if the provider fee is $100 but the plan allows only $70, an out-of-network provider may bill YOU the extra $30. This is called balance billing.

Medical

BLUE CROSS BLUE SHIELD OF ILLINOIS

An HMO Plan gives you more predictable costs but less flexibility. You pay a copay for most services, but all care must be received within the **Blue Advantage HMO** or **HMO Illinois** network depending on the plan option you choose. Out-of-network care is not covered except in an emergency. You must choose a primary care physician (PCP) to manage routine care, referrals, and hospital stays. Enrollment in HMO requires selection of doctor, see page 10 and 11 for information needed.

A PPO Plan gives you flexibility and choice, for a price. You can go to any doctor without a referral, but you will pay a larger share of the cost if they are not in the **PPO** network. In some cases, you'll need to meet a deductible before the plan starts to pay.

Questions? Call BCBS customer service at (855) 649-9653 or visit www.bcbsil.com.

	Blue Advantage HMO	HMO Illinois	PPO	
	In-network only	In-network only	In-network	Out-of-network
Annual deductible	$0 per individual; $0 family limit	$0 per individual; $0 family limit	$500 per individual; $1,500 family limit	$700 per individual; $2,100 family limit
Annual out-of-pocket maximum	$1,500 per individual; $3,000 family limit	$1,500 per individual; $3,000 family limit	$1,800 per individual; $5,400 family limit	$10,000 per individual; $30,000 family limit
Primary provider office visit	$30 copay then Plan pays 100%	$30 copay then Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist office visit	$50 copay then Plan pays 100%	$50 copay then Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible
Virtual visit	Not covered	Not covered	Plan pays 80% after deductible	Not covered
Preventive care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 60% after deductible
Diagnostic lab and X-ray	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 80%
Urgent care	$30 copay then Plan pays 100%	$30 copay then Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency room	$150 copay then Plan pays 100% (copay waived if admitted)	$150 copay then Plan pays 100% (copay waived if admitted)	$150 copay then Plan pays 100% (copay waived if admitted)	$150 copay then Plan pays 100% (copay waived if admitted)
Hospitalization	1st 5 days: $100 copay per day then Plan pays 100%; thereafter: Plan pays 100%	1st 5 days: $100 copay per day then Plan pays 100%; thereafter: Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient surgery	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 80%

	Blue Advantage HMO	HMO Illinois	PPO	
	In-network only	In-network only	In-network	Out-of-network
PRESCRIPTION DRUGS				*CVS, including those within Target, is out-of-Network*
Annual out-of-pocket maximum	$1,000 per individual; $2,000 family limit	$1,000 per individual; $2,000 family limit	$1,000 per individual; $3,000 per family	Combined with in-network
Generic	**Pharmacy:** $10 copay then Plan pays 100%; **Mail order:** $20 copay then Plan pays 100%	**Pharmacy:** $10 copay then Plan pays 100%; **Mail order:** $20 copay then Plan pays 100%	**Pharmacy:** $10 copay then Plan pays 100%; **Mail order:** $20 copay then Plan pays 100%	**Pharmacy:** $10 copay then Plan pays 75%; **Mail order:** Not covered
Preferred brand	**Pharmacy:** $40 copay then Plan pays 100%; **Mail order:** $80 copay then Plan pays 100%	**Pharmacy:** $40 copay then Plan pays 100%; **Mail order:** $80 copay then Plan pays 100%	**Pharmacy:** $40 copay then Plan pays 100%; **Mail order:** $80 copay then Plan pays 100%	**Pharmacy:** $40 copay then Plan pays 75%; **Mail order:** Not covered
Non-preferred brand	**Pharmacy:** $60 copay then Plan pays 100%; **Mail order:** $120 copay then Plan pays 100%	**Pharmacy:** $60 copay then Plan pays 100%; **Mail order:** $120 copay then Plan pays 100%	**Pharmacy:** $60 copay then Plan pays 100%; **Mail order:** $120 copay then Plan pays 100%	**Pharmacy:** $60 copay then Plan pays 75%; **Mail order:** Not covered
Specialty	**Pharmacy:** $80 copay then Plan pays 100%	**Pharmacy:** $80 copay then Plan pays 100%	**Pharmacy:** $80 copay then Plan pays 100%	Not covered
Number of days' supply	**Pharmacy:** 34 days; **Mail order:** 90 days	**Pharmacy:** 34 days; **Mail order:** 90 days	**Pharmacy:** 34 days; **Specialty Pharmacy:** 30 days; **Mail order:** 90 days	**Pharmacy:** 34 days; **Mail order:** Not applicable
VISION				
Exam	Plan pays 100% once every 12 months	Plan pays 100% once every 12 months	$25 copay then Plan pays 100% once every calendar year	Combined with in-network
Frames	$125 allowance once every 24 months	$125 allowance once every 24 months	$20 allowance once every calendar year	Combined with in network
Single, bifocal or trifocal lenses	Plan pays 100% once every 24 months	Plan pays 100% once every 24 months	$20, $35 or $40 allowance once every calendar year	Combined with in-network
Contacts (elective)	$75 allowance once every 24 months	$75 allowance once every 24 months	$100 allowance once every calendar year	Combined with in-network
COST (bi-weekly)				
Employee only	$36.07	$38.78	$74.12	
Employee + 1	$75.10	$80.76	$167.48	
Employee + 2 or more	$104.81	$112.70	$260.83	

Prescription Coverage

Are prescription drug costs breaking your budget?

A little research before you go to the pharmacy could result in huge savings.

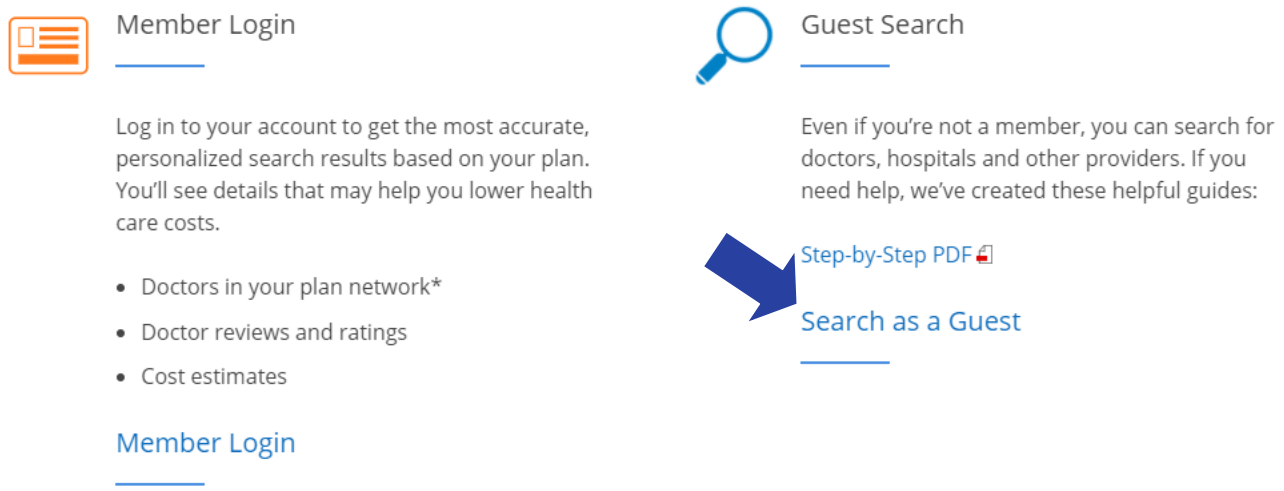
	Insider tip	Rx expert!
	Your medical plan includes prescription drug coverage. You pay a different amount depending on the "tier" or class of drug.	GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there's a generic alternative.
	A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan's preferred drug list.
	A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan's website or by calling member services. **Reminder, CVS Pharmacy (both free standing and those within the Target Store) are out of network on the PPO plan.**	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or lowestmed.com
	SPECIAL HANDLING REQUIRED? Your plan may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from BCBSIL's specialty pharmacy, Accredo.	Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures. Before filling your prescription, verify that the pharmacy is in-network.
	You can get medicines that you take routinely by MAIL ORDER. Your doctor will need to authorize a 90-day supply. You can submit refills through a website or app, or by phone. **Mail Order:** Express Scripts www.esrx.com/BCBSIL or (833) 715-0942	Compare your plan's mail-order copay and shipping costs against your local pharmacy price and/or other discount programs. If it's less expensive locally, ask if your doctor can write a 90-day prescription rather than a 30-day one.

How to Find a Doctor

You get the most out of your medical plan by using an in-network provider.

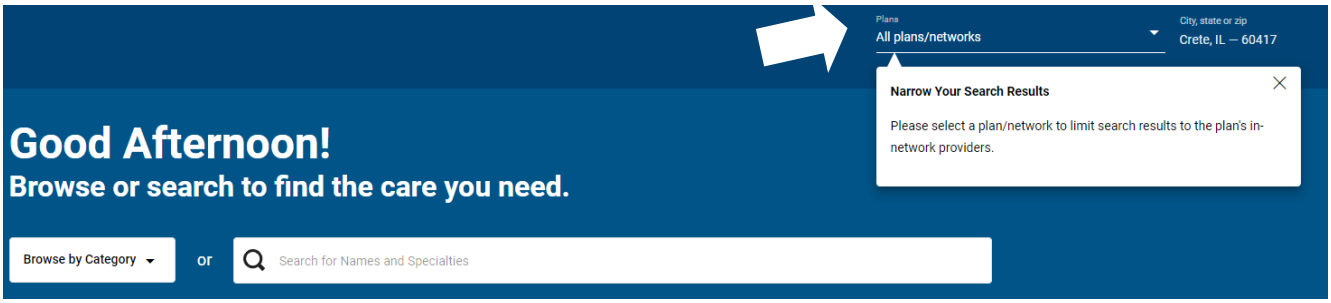
To see if your provider participates in the Blue Cross Blue Shield network—or to find one who does—simply log on to https://www.bcbsil.com/find-care/providers-in-your-network/find-a-doctor-or-hospital.

Under "Find a Doctor or Hospital" click on "Search as a Guest".



On the next page under the "All plans/network" drop down, select the applicable network.

- PPO ➡ **Participating Provider Organization [PPO]**
- BA HMO ➡ **Blue Advantage HMO [ADV]**
- HMO IL ➡ **HMO Illinois [HMO]**



Fill in criteria you have, doctor's name, zip code of area you want to find a doctor in, etc. Then pick one of the providers listed.

How to Find a Doctor, Continued

If you are enrolling in one of the two HMO plan options, you are required to choose a Primary Care Physician (PCP) and Medical Group (IPA) who participates in the selected HMO network and who is available to accept you and/or your family members.

You will need the 9-digit PCP#:

Provider Highlights

Noel E Lasala, MD

PCP ID: 240116357

LOCATION
3224 W Armitage Ave, Chicago, IL 60647
Get directions (est. 4.3 miles away)

CONTACT INFORMATION
Phone: 847-884-7771

Accepting New Patients

3.0 out of 5.0 2 ratings.

Speaks Tagalog + 2 More languages

Log In for personalized results

And the 3-digit IPA#:

AFFILIATED MEDICAL GROUPS

Amita Hlth St Mary Elizabeth Med (MG/IPA #497)

Unified Physicians Network (MG/IPA #145)

Once you select one note the IPA# and Group name and the PCP# and doctor's name to fill in the enrollment form:

Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____

If HMO: Medical Group/IPA #: _ _ _ _ _ _ _ _ _ _ Medical Group/IPA Name: _____

PCP #: _ _ _ _ _ _ _ _ _ _ PCP Name: _____ WPHCP Medical Group/IPA#: _ _ _ _ _ _ _ _ _ _

Preventive Care & You

Your body doesn't come with an owner's manual, but you have to take care of it to make sure it will keep running for a long time. An important part of self-care is getting preventive medical exams to check that you're staying healthy or to identify and treat diseases before they become serious.

WHAT IS PREVENTIVE CARE?

TESTS
Blood pressure
Diabetes
Cholesterol

CHECKUPS
Well baby
Well child
Well woman

Mammograms
Colonoscopies
CANCER SCREENINGS

Prenatal care for healthy pregnancy & healthy baby
PREGNANCY

VACCINATIONS
Flu, pneumonia, measles, polio, meningitis, and other diseases

Screenings for sexually transmitted infections
STD

TALK WITH YOUR DOCTOR ABOUT
Tobacco use, healthy weight, exercise, eating habits, alcohol use, depression

FOR MORE RESOURCES, VISIT CDC.GOV/PREVENTION

Recommended preventive care and healthy lifestyle choices are key steps to good health and well-being.

Prevention is a habit

- Make healthy lifestyle choices —food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.

Know your numbers

Keep a record of your health screening dates and results so you can talk to your doctor about any changes.

- Date of last checkup
- Height and weight
- Blood pressure
- Cholesterol
- Immunizations and vaccines
- Other test results

What preventive care do you need?

Visit **healthfinder.gov** and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.

Preventive Care & You, Continued

Is it preventive or diagnostic?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's covered at 100%.

But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

Preventive Care Services

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider

Diagnostic Services

- Check for disease after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost

PREVENTIVE: At Don's annual checkup, his doctor orders a blood sugar test to screen for diabetes, even though Don does not have symptoms.

DIAGNOSTIC: Grace's doctor orders a blood sugar test because she complains of increased thirst, frequent urination, weight loss, and fatigue—all symptoms of diabetes.

PREVENTIVE: As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.

DIAGNOSTIC: Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.

PREVENTIVE: Aki's doctor orders lab work during his annual physical, including a cholesterol check.

DIAGNOSTIC: Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you're unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.

Know Where to Go

Emergency room, urgent or virtual care?

The emergency room shouldn't be your first choice unless there's a true emergency.

PPO enrollees can consider virtual care (MDLive) for...

You can video chat with a doctor from the comfort of their own home, without an appointment. MDLIVE doctors can help treat the following conditions and more:

- Allergies
- Asthma
- Nausea
- Sinus infections
- Cold
- Flu
- Ear problems
- Pinkeye

Consider urgent care for...

Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as:

- Earache
- Sore throat
- Rashes
- Sprains
- Broken fingers or toes
- Flu
- Fever up to 104 degrees

Go to the emergency room for...

Serious or life-threatening conditions that require immediate treatment that you can get only at a hospital, such as:

- Chest pain or severe abdominal pain
- Trouble breathing
- Loss of consciousness
- Severe bleeding that can't be stopped
- Large broken bones
- Major injuries from a car crash, fall or other accident
- Fever above 104 degrees

Go to the nearest emergency room regardless of your plan choice.

Other non-emergency care options

Our medical plans offer plenty of options when you need care or advice, but it's not an emergency:

Plan	Call a nurse 24/7	Connect with MDLive	Find doctor/urgent care
Blue Cross Blue Shield of Illinois Medical PPO	(800) 299-0274	Visit the website mdlive.com/bcbsil or download the mobile app or call (888) 676-4204 for access to board-certified doctors **24 hours a day,** seven days a week.	Find urgent care centers near you by texting **URGENTIL** to **33633** and then type in your ZIP code or by visiting www.bcbsil.com or calling the number on the back of your ID card.
Blue Cross Blue Shield of Illinois Medical HMO – BA HMO or HMO IL	Not Available	Not Available	If possible, try to call your Primary Care Physician (PCP) before going to an urgent care center. The urgent care facility must be affiliated with your chosen medical group, or a referral is required.

PPO Plan Alternative Facilities

If you have a life-threatening medical emergency, your first concern is getting help as soon as possible. But if you have more time to evaluate your options, you may be able to save big bucks by shopping around. Alternative facilities can provide the same results as a hospital at a fraction of the cost.

SURGERY: Consider an Ambulatory Surgery Center (ASC)

An ASC is a healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more. ASCs are held to the same types of patient safety standards as hospitals. ASC prices can be as much as 50% lower than hospital outpatient charges for the same procedure.

PHYSICAL THERAPY: Stay free standing

Physical therapy (PT) can be an important part of recovery after an injury or surgery. On average, PT in a free standing center can cost 40 to 60% less than PT delivered in a hospital setting.

SLEEP STUDY: There's no place like home

If you have a condition like sleep apnea, your doctor may recommend an overnight sleep study. The cost is often covered by insurance if the test is considered medically necessary. Overnight tests in a sleep center may cost up to $5,000 per night; however, a home test often costs less than $500.

HOME INFUSION THERAPY: Avoid a costly hospital stay

Infusion therapy may be prescribed when a patient must receive intravenous drugs, injections, or epidurals instead of oral medications. Treatment by a licensed infusion therapy provider at home or at an outpatient center can be safe and effective. Avoiding a hospital stay can provide savings of up to 90%, and also helps maintain a normal lifestyle in the comfort of home.

How to find an alternative treatment facility

If your treatment involves a visit to a hospital operating room or clinic, ask your doctor if you can get the same medical care somewhere else. If you are doing your own research, start with your plan's "find a provider" link to search for surgical centers, physical therapy, and more. Or call your plan's member services for assistance. Finding an in-network facility ensures you get the plan's negotiated rates.

Cost and quality data

In addition to your health plan website, online tools such as healthcarebluebook.com and healthgrades.com help you compare procedure costs and doctor quality ratings to help you make decisions about your healthcare.

Beware of extra fees

Be aware that many hospitals, treatment centers, and even primary care doctor's offices have begun to charge a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Get the Most from Your BCBS Plan

Connect to Blue Access for Members

Connect to www.bcbsil.com/member to get plan details and personalized health information whenever and wherever you need it! Use it to:

- Find network care, compare costs, and use the mapping tool to get directions.
- See what's covered and get information about preventive care that's covered at no cost to you.
- View claim details, account balances and your Explanation of Benefits (EOB).
- Quick-link tools to prescription drug information through Prime Therapeutics. Direct: www.myprime.com

It's quick and easy. Find the "Log In" tab and click "Register Now". Use the information on your ID card to complete the process.

HMO Guest Membership

This program covers members, like college students, who are living out of the participating service area for at least 90 consecutive days. You can become a Guest Member with full benefits through a BCBS HMO in another state. Guest Membership is a particularly valuable benefit for covered students who are living out of state while attending school or for members on extended travel out of state. To find out if guest membership is available at your destination or to sign up with a host BCBS HMO in another state, you must call Customer Service before leaving home or before receiving any out-of-state services. If not, there will be no coverage for services received out of state. After applying, if you plan to continue with guest membership, you must renew it after a defined period of time.

Going Abroad?

PPO Participants traveling outside the United States can call (800) 810-2583 or call collect to (804) 673-1177 for medical assistance services. BCBSIL has contracts with doctors and hospitals in more than 190 countries. An assistance coordinator, in conjunction with a medical professional, can arrange your doctor's appointment or hospitalization, if necessary.

HMO Plan Participants have coverage abroad only in an emergency. Call the number on the back of your ID card for details.

Vision Care Discounts

EyeMed | Davis Vision

You may save on eye exams, eyeglasses, contact lenses and accessories. You have access to national and regional retail stores and local eye doctors. You may also get possible savings on laser vision correction.

Identity Theft Protection

Experian, ProtectMyID

For help with daily credit monitoring and alerts call (866) 926-9803 and reference Engagement Number PC98484.

BLUE365

Access to wide range of health and well-being deals for national and local providers. Save money on gym memberships, vision exams and services, hearing aids and diet-related services. Share deals with friends and family and receive cash rewards on future offers. Sign up for Blue365 at www.blue365deals.com/bcbsil and weekly "Featured Deals" will be emailed to you.

Well on Target

The Well onTarget Member Wellness Portal provides you with tools to help you set and reach your wellness goals. Visit www.wellontarget.com to register. When you log in, you will find a wide variety of health and wellness resources, including:

- A Health Assessment (HA)
- Self-directed courses
- Health trackers
- Trusted news and health education content

Dental

BLUE CROSS BLUE SHIELD OF ILLINOIS

Dental coverage provides periodic preventive care, and if there's a problem, helps with the cost of dental work. Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

ALA offers you a choice of dental plans through BCBS. You are covered at a higher level if you receive care from a provider in the **BlueCare Dental PPO** network rather than outside of the network.

Questions? Call BCBS customer service at (855) 367-6401 or visit www.bcbsil.com.

	Low PPO Plan		High PPO Plan	
	In-network	Out-of-network*	In-network	Out-of-network*
Annual deductible	$75 per individual; $225 family limit	Combined with in-network	$50 per individual; $150 family limit	Combined with in-network
Annual plan maximum	$1,250	Combined with in-network	$2,500	Combined with in-network
Diagnostic and preventive	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic services				
Fillings, root canals, periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major services				
Bridges, Dentures, implants, crowns	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Orthodontia				
Orthodontia	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Dependent children (up to age 19)	Covered	Covered	Covered	Covered
Adults	Not covered	Not covered	Not covered	Not covered
Lifetime maximum	$1,000	Combined with in-network	$1,000	Combined with in-network
COST (bi-weekly)				
Employee only	$2.11		$4.45	
Employee + 1	$4.77		$9.59	
Employee + 2 or more	$9.26		$17.21	

** Your out-of-pocket cost may be greater because Non-Contracting Providers have not entered into a contract with BCBSIL to accept the Maximum Allowable In-Network Amount as payment for Eligible Dental Expenses.* You *are required to file claim form. You are balance billed for costs exceeding the BCBSIL Allowable Amount. Non-contracting provider reimbursement MAC.*

Vision

EYEMED VISION CARE

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease. ALA offers you a vision plan through EyeMed. You are covered at a higher level if you receive care from a provider in the **Insight** network. To receive out-of-network benefits you must submit for reimbursement.

Questions? Call EyeMed's customer service at (866) 804-0982 or visit www.eyemed.com.

	In-network (Insight)	Out-of-network
Frequency		
Examination	1 x every 12 months from last date of service	In-network limitations apply
Frames	1 x every 24 months from last date of service	In-network limitations apply
Eyeglass lenses	1 x every 12 months from last date of service (instead of contacts)	In-network limitations apply
Contacts (elective)	1 x every 12 months from last date of service (instead of eyeglass lenses)	In-network limitations apply
Benefit		
Examination	$10 copay then Plan pays 100%	Reimbursement up to $40
Frames	$130 allowance, plus Plan pays a 20% discount from the remaining balance	Reimbursement up to $91
Single vision lenses	$25 copay then Plan pays 100%	Reimbursement up to $30
Bifocal lenses	$25 copay then Plan pays 100%	Reimbursement up to $50
Trifocal lenses	$25 copay then Plan pays 100%	Reimbursement up to $70
Contacts (elective)	$130 allowance, plus Plan pays a 15% discount from the remaining balance	Reimbursement up to $130
Contact lens fit and follow-up	Up to $40 copay then Plan pays 100%	Not available
COST (bi-weekly)		
Employee only	$2.60	
Employee + 1	$4.94	
Employee + 2 or more	$7.26	

Additional in-network discounts: 40% off a complete pair of prescription eyeglasses, 20% of non-prescription sunglasses, 20% of remaining balance beyond plan coverage and more.

EyeMed also teams up with Amplifon – the world's largest distributor of hearing aids and services! Amplifon provides 40% off hearing exams, discounts on hearing aids, 1 year fee follow-up care, free batteries for 2 years with initial purchase and more to EyeMed vision participants. Questions? Call Amplifon's customer service at (844) 526-5432 or visit www.amplifonusa.com.

Flexible Spending Accounts (FSA)

WEX

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend, and reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by December 31 of 2023. Otherwise, money can be lost, so plan carefully. You must re-enroll in this program each year.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Expenses must be incurred between 01/01/23 and 12/31/23 and submitted no later than 03/16/24.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- ALA allows a roll-over up to $610 of unused Healthcare FSA money for use in the next plan year. Unused Healthcare FSA amounts above $610 by 12/31 of plan year will be lost, so it is very important that you plan carefully before making your election.
- Healthcare FSA funds can be used for eligible expenses incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on the ALA health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).

Tax-Free Healthcare FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to **$3,050** per year (minimum $5 per paycheck).

Tax-Free Dependent Care FSA

Eligible expenses may include daycare centers, in-home childcare, and before or after school care for your **dependent children under age 13.** Other individuals, including elders, may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to **$5,000** (**minimum $5 per paycheck**) per household for eligible dependent care expenses (not including healthcare expenses) for the year.

Flexible Spending Accounts (FSA), Continued

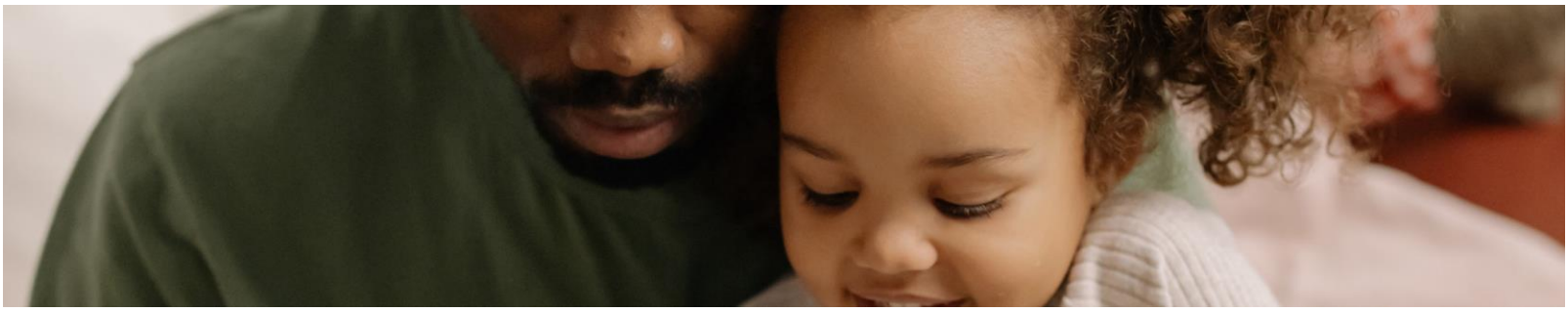
IMPORTANT CONSIDERATIONS CONTINUED

- If you or your spouse are enrolled in a high deductible health plan (HDHP) through another employer, you cannot participant in the FSA if you contribute to a Health Savings Account (HSA).
- During the year, you can use your Healthcare FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses. You will need to keep your receipts as proof that your expenses were eligible, as you may be required to submit documentation relating to your health care purchase. IRS requires that all transactions be substantiated.
- Dependent Care FSA funds are available for reimbursement only after money is deducted from payroll and after the date of service has passed.

FSA Savings Example

	Without FSA	With FSA
Annual Pay	$60,000	$60,000
Pre-Tax FSA Contributions for Healthcare Expenses	$0	($2,000)
Taxable Income	$60,000	$58,000
Federal Taxes	($10,852)	($10,259)
After-Tax Healthcare Expenses	($2,000)	$0
NET INCOME	**$47,148**	**$47,741**

Your savings will depend on your income, tax bracket, and FSA contribution amount.



Life Insurance

BLUE CROSS BLUE SHIELD OF ILLINOIS

Life insurance can fill a number of financial gaps for a family recovering from the death of a loved one. Without enough life insurance, many families have to reduce their standard of living after the loss of an income. Consider your current and future financial needs when evaluating how much coverage you need. The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses, e.g., college education, or home mortgage
- Taxes and debts that need to be settled.

YOUR BENEDICARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change you beneficiary as needed if your situation changes.

ALA-provided Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident. The cost of coverage is paid in full by the company. Benefit reduces by 50% of original amount at age 70.

Basic Life	2 x covered annual earning (excluding any bonus or commissions) up to $300,000.
Basic AD&D	1.5 x covered annual earnings (excluding any bonus or commissions) up to $150,000.

A note about taxes: Group Term Life (GTL) under IRS regulations, a life insurance benefit over $50,000 is considered taxable income to the covered individual. You will see the value of the benefit over $50,000 included in your taxable income on your paycheck and W-2. The taxable amount or "imputed value" of such insurance is determined by the IRS and is added to your taxable wages.

Voluntary Life

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse/domestic partner and/or child(ren) if you purchase coverage for yourself. Benefit reduces by 50% of original amount at age 70.

Employee	1x to 5x salary up to $1,000,000. Guaranteed issue is $250,000.
Spouse/Domestic Partner	$25,000 or $50,000; not to exceed 50% of employee amount. Guaranteed issue is $25,000.
Child(ren) up to age 26	$10,000. Guaranteed issue is $10,000.

If you select coverage above the "guaranteed issue" amount or if the value increases beyond the guaranteed amount due to salary increases or if you select coverage for the first time after your initial eligibility period, you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage. During Open Enrollment, if you are currently enrolled, you may “bump up” your Life coverage by 1x your salary, up to the "guaranteed issue" amount without Evidence of Insurability.

Disability Insurance

BLUE CROSS BLUE SHIELD OF ILLINOIS

Most people underestimate their likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Voluntary Short-term disability

Issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

Long-term disability

Longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke

Voluntary Short-term Disability

Short-term disability (STD) coverage through Blue Cross Blue Shield of Illinois pays a benefit if you temporarily can't work because of an injury, illness, or pregnancy. You pay the cost of this coverage. Full-time or part time (.5 fte) employees are eligible for the disability benefits.

Weekly benefit amount	60% of covered weekly earnings up to a maximum of $2,000
Benefits begin	After 14 days of disability due to accident or 14 days due to sickness
Pre-Existing Conditions * Pre-existing conditions apply to New Hires enrolling for the first time and employees who previously waived coverage as new hires but would like to enroll for the first time at Open Enrollment.	A Pre-Existing Condition is an accident or sickness (including pregnancy) for which you have received treatment, consultation, care or service or were prescribed prescription medications within 12 months prior to your effective date. Any disability contributed to or caused by a Pre-Existing Condition within the first 12 months of your effective date will not be covered. **Example 1:** Melissa Ingles is electing STD coverage for the first time. In this example Melissa's benefit will become effective January 1, 2023. In February of 2023, Melissa announces she is 4 months pregnant. Since her pregnancy began in November of 2022 prior to the January 1, 2023, effective date of the policy, it would be considered a pre-existing condition and not be covered. BUT if Melissa becomes pregnant again the following calendar year that occurrence would be covered. **Example 2:** Lucy Brown, like Melissa, is electing STD coverage for the first time. In this example Lucy's benefit will also become effective January 1, 2023. In June of 2023, Lucy announces she is 4 months pregnant. Since her pregnancy began in February of 2023 after the policy became effective on January 1, 2023, this will be a covered disability.
Maximum payment period	26th week of disability (based on the first day you are disabled, not when benefits begin)

Disability Insurance, Continued

ALA-provided Long-term Disability

If you can't work for a longer time, long-term disability (LTD) coverage through Blue Cross Blue Shield of Illinois replaces part of your monthly income. If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The cost of coverage is paid in full by the company for full-time or part time employees (.8 fte).

Monthly benefit amount	60% of covered monthly earnings up to a maximum of $10,000
Benefits begin	After 180 days
Maximum payment period	Later of age 60 or SSNRA (The age at which disability begins may affect duration of benefits.)

Travel Resource Services (through Blue Cross Blue Shield)

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Our Travel Resource Services provider, Assist America, offers around the clock emergency and information services that can help you access assistance when you are traveling 100 or more miles away from home. Help is there when a crisis strikes. Call (800) 872-1414 in the US or +1 (609) 986-1234 from other locations. Your Assist America Reference Number is: 01-AA-TRS-12201

Travel Accident Insurance

ALA also provides full-time employees with an additional $250,000 in life insurance protection for you while traveling on ALA business.

Voluntary Policies

GUARDIAN

Voluntary Hospital Indemnity

Hospital indemnity insurance from Guardian can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

Hospital Admission	$1,000
Wellness benefit	**$50 per insured per year**
COST (Semi-monthly)	
Employee only	$9.43
Employee + Spouse/Domestic Partner	$17.02
Employee + Child(ren)	$15.05
Employee + Family	$22.64

Voluntary Accident

Accident Insurance from Guardian helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

BENEFIT TYPE	BENEFIT PAYOUT*
Ambulance	$200 ground, $1,000 air
Burn	Up to $12,000
Concussion	$150
Diagnostic Testing (Major)	$200
Dislocation	Schedule up to $5,000
Emergency Room Treatment	$200
Follow-up Treatment	$50 per visit, up to 6 visits
Fracture	Schedule up to $6,000
Hospital Admission	$1,000
Hospital Confinement	$250 per day, up to 1 year
Laceration	Schedule up to $400
Outpatient Therapies	$35 per day, up to 10 days
Surgery	Schedule up to $1,250
Urgent Care	$100
Wellness Benefit	**$50 per insured, per year**
COST (Semi-monthly)	
Employee only	$6.51
Employee + Spouse/Domestic Partner	$10.28
Employee + Child(ren)	$10.77
Employee + Family	$14.54

Voluntary Policies, Continued

Voluntary Critical Illness

Critical illness insurance from Guardian can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

BENEFIT AMOUNT	
Employee	$10,000 or $20,000
Spouse/Domestic Partner	$5,000 or $10,000 not to exceed 50% of employee's election
Child	25% of employee's benefit
Guarantee Issue	Yes, for new hires and at each annual enrollment

BENEFIT TYPE	PERCENTAGE OF BENEFIT PROVIDED*
Benign Brian Tumor	75%
Cancer (invasive)	100%
Carcinoma in Situ	30%
Coma	100%
Coronary Artery Disease w/ Bypass	30%
Heart Attack	100%
Kidney Failure	100%
Organ Failure	100%
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs
Stroke	100%
Wellness Benefit	**$50 per EE/SP/CH, per year**

See page 32 for cost details.

**Please refer to the plan documents for a comprehensive list of covered benefits, exclusions and eligible wellness tests.*

ALLSTATE

Identity Theft Protection

We have Allstate Identity Protection (AIP) to address the surge in identity theft we have seen. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from Allstate helps protect your personal information through proactive monitoring, identity restoration, and resolution. The plan also comes with a $1 million identity theft insurance policy, so your identity is fully protected. Questions? Visit www.myaip.com or call (800) 789-2720. This program offers a generous definition of family, using "under roof or under wallet" as their guideline. As long as your dependent lives within your household, or you support the individual financially, they are eligible to enroll at any age. This includes college aged children and elderly parents.

Other Benefits

Transit & Commuter

Do you have out-of-pocket commuting expenses for public transportation or for worksite parking? If so, you can save on taxes by enrolling our transit/commuter plan (also known as a Section 132 plan). A transit/commuter plan lets you set aside money—before it's taxed—through payroll deductions. You may enroll and/or stop participating in this program at any time throughout the year (subject to deadlines to be effective).

Here are the maximum amounts of money you can set aside:

Parking Expense Account	Up to $300 per month
Transportation Expense Account	Up to $300 per month

The transit / commuter program is use it or lose it. Your contributions are intended to be used in that month the deductions are taken. **Any unused funds from one month are forfeited; carryover from month to month is prohibited.**

Note that requests for enrollments and changes are due by the 6th of the month to be effective the start of the next month. Any requests received after the 6th will be held until the following month. These amounts are evaluated annually by the IRS and are subject to change. Deductions are made from the 1st and 2nd check of the month, if there is a 3rd check in the month that will not have any deductions for transit.

See the ALA support site for an enrollment form.

Tuition Reimbursement*

ALA's Tuition Reimbursement Program encourages and supports employees to continue their development. Once you have been in a regular position for 6 months, with a preapproved request, courses from an accredited college or university that are job related are eligible for up to 50% reimbursement of the cost of tuition, books, registration and lab fees. Undergraduate courses are limited to $2,000 and Graduate courses to $4,000 total per fiscal year.

Workers' Compensation Coverage*

ALA provides a safe working environment and wants all employees to be safe in the performance of their job. If anyone sees a potentially unsafe or hazards working conditions notify your supervisor. Employees working for ALA are covered for any work-related injuries under our Workers' Compensation Policy in the event they sustain an injury while performing the duties for ALA.

In the event you do sustain an injury in the process of performing your job contact your supervisor for immediate medical assistance. Once you are medically stable, report the incident to your supervisor who should then contact Human Resources to file a report of the incident.

**** See Policy Handbook for full details.***

Credit Union

Money Matters, you pick how you manage what you have and it is good to have options. If you already have a relationship with a bank why would you want to join a credit union???? You ask.

Membership in a Credit Union can offer advantages not available through a bank. Although many services are similar if not the same as what a bank offers, a Credit Union can provide services at lower costs or with fewer exceptions than a bank such as:

- Direct Deposits and Online Banking
- Cable and wire deposits
- Financial education and counseling services
- High interest rates on savings accounts, CDs and money market accounts
- Investment services
- Low cost or free checking with low or no minimum balance requirements
- Low interest rates on mortgages and vehicle loans and more.

Library of Congress Federal Credit Union
Other resources are available online at www.lcfcu.org/home/home or by calling (202) 707-5852 or (800)325-2328.

Enroll online following the link below:
www.lcfcu.org/home/services/applications/membership

Central Credit Union of Illinois
Illinois https://www.centralcu.org/ who also has some great benefits as well. Other resources are available by calling (708) 649-6420.

(Download an enrollment form https://www.centralcu.org/seg-join-central-credit-union)

Employee Assistance Program (EAP) (through Blue Cross Blue Shield)

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through ComPsych GuidanceResources can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, financial counseling, and retirement planning. Best of all, it's free and confidential.

Help is available 24/7, 365 days a year by telephone at (866) 899-1363 (TDD: (800) 697-0353). When you call, please make sure to reference Blue Cross Blue Shield / Dearborn. Other resources are available online at www.guidanceresources.com. When you log in, enter DISRES as your web ID. In-person counseling may also be available, depending on the type of help you need. The program allows you, the employee, up to 3 visits.

Retirement Plan 403(b)

Retirement is important for everyone to start planning for no matter how far off in the future it may be. ALA makes it easy for you to save for retirement by allowing you to start contributing from day one of your employment. Changes to contributions can be made at any time throughout the year. We have two types of retirement accounts with TIAA:

Group Supplemental Retirement Annuity (soon to be Retirement Choice Plus)

- Loans allowed from this account ONLY, withdrawal while still working at ALA (see plan details)

ALA Retirement Annuity (soon to be Retirement Choice)

- ALA contributes to your retirement in this account, you contribute here to get the ALA match, no withdrawals are allowed until after you leave ALA

At your two-year anniversary, once you open an ALA Retirement Annuity, per plan guidelines, ALA will begin contributing to your account in the following ways:

- You will receive 4% of your annualized salary contributed to your **ALA Retirement Annuity Account**.
- If you contribute 3% of your salary to your **ALA Retirement Annuity Account,** ALA will match the 3%.
- In total, you can receive up to 7% of your salary in contributions to your retirement
- Once you open the ALA Retirement Annuity the first ALA contributions can begin the first full pay period AFTER your 2nd anniversary of employment in a regular benefit eligible position.

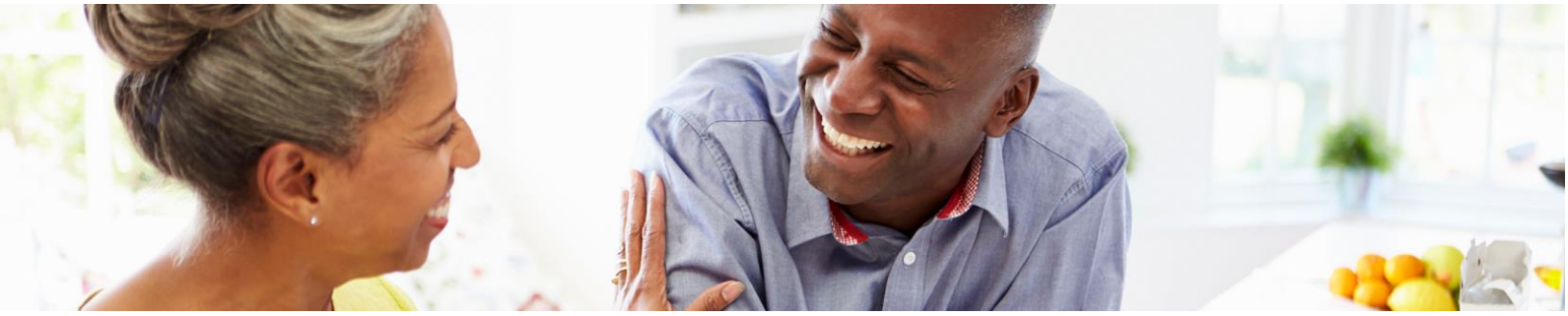
Employee annual contribution limits are set by the IRS

Year	403(b) Contribution limits	Catch up Contribution (age > 50)
2023	$20,500	$7,000
2022	$20,500	$7,000
2021	$19,500	$6,500

See www.tiaa.org for details regarding the plan's investment options, performance history, as well as the fees and expenses associated.

Other resources are available online at www.tiaa.org. Account counseling is available by calling (800) 842-2252. To schedule an in-person consultation with TIAA call (800) 732-8353. Update beneficiaries as necessary by logging into your TIAA account or calling (800)842-2252.

******* Once enrolled in the plan, you will be able to manage your account online and change your contribution distributions directly on the TIAA website**



Retiree Benefits

Those employees who retire from ALA after age 62* have the opportunity to continue health coverage with the ALA health plans. Those over 65 are eligible for a BCBS Medicare Advantage Plan, anyone under 65 stays on the ALA group plan until they become eligible for the BCBS MA Plan. The retiree pays a reduced rate for their medical and dental coverage based on their years of service

Length of Full-Time Service	ALA Premium Contribution	Retiree Contribution
5-14 years	25%	75%
15-19 years	50%	50%
20 years or more	75%	25%

Eligibility to continue coverage is based on the most recent 5 years before retirement of continuous enrollment in the ALA health insurance plans including medical, dental and vision to enroll as retirees.

Note that once a retiree waives or drops any plan coverage there is no option to enroll in plan(s) again in a subsequent year.

- Medical coverage as a retiree
  - Medical coverage under age 65 is on the ALA group health plan with the same options as current employees.
  - Medical coverage at 65 and over, or at becoming Medicare eligible, for retirees and dependents on their plans is with BCBS Medicare Advantage Plan *(BCBS MA). Once retiree or spouse or domestic partner turns 65 they move to the BCBS MA plan and the other participant(s) stay on the group plan until they turn 65, the same rate of cost contribution applies as outlined above.
    - *BCBS Medicare Advantage is an enhanced employer plan that covers both in network and out of network costs, and is not a generic plan advertised for the general public.
- Dental Insurance can be continued with the ALA group plans, the same rate of cost contribution applies as outlined above.
- Vision Insurance can be continued with the group plans (no ALA contribution).
- Retiree Life Insurance Policy value up to age 70 is $5,000 and age 70+ value is $2,500

**See Policy Handbook for full details.*

Pet Benefits

ALA offers pet benefit to employees at exclusive group rates! You can enroll in Pet Assure, PetPlus, or both. Pet coverage is brought to you by Pet Benefit Solutions. Choose the plans that work best for you and your Pets.

Pet Assure Veterinary Discount Plan

Established in 1995, Pet Assure is America's Veterinary Discount Plan. As an alternative or addition to pet insurance, Pet Assure helps pet owners like you save on veterinary care.

Pet Assure members save 25% at participating veterinarians on all in-house medical services, including:

- Office Visits
- Vaccinations
- X-Rays
- Dental Work
- Spay & Neuter
- Emergency Visits
- Surgeries
- Hospitalization

It's as simple as that: since Pet Assure is not insurance, there are no forms to fill out, no waiting for reimbursements and no denials of coverage – even pets with pre-existing conditions are accepted.

Pet Assure has participating veterinarians in all 50 states and Puerto Rico. Search for a veterinarian at www.petbenefits.com/search.

Pet Assure also includes a 24/7 Lost Pet Recovery Service.

$8.00/month for an unlimited number of pets.

PetPlus Product and Rx Discount Plan

With PetPlus, you receive members-only pricing on prescriptions and everything else your pet needs. View available products and pricing at www.petbenefit.com.

PetPlus members save up to 50% on:

- Prescription Medications
- Flea & Tick Products
- Vitamins & Supplements
- Heartworm Preventatives
- Food (Rx & Non-Rx)
- Treats & Supplies

It's easy to shop at your members-only pricing at www.petcarerx.com. Get free shipping on all online orders and same-day pickup is available for most prescriptions at any Caremark pharmacy nationwide, including Walgreens, Target, CVS and other local pharmacies.

Plus also includes 24/7 Pet Telehealth powered by AskVet.

$4.50/month for one dog or cat or $8.50/month for all of the dogs and cats in your home.

Visit www.petassure.com/land/americanlibrary to learn more about your plan options and how to enroll.

Time Off & Holidays

Accrued Time Off*

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can relax, recover from illness, and take care of personal business.

	Full Time Exempt Accrual rate	Full Time Non-Exempt Accrual rate	Part Time Non-Exempt Accrual rate	Temporary
Vacation time	5.92 hrs. per pay period /22 days a year	4.04 hrs. per pay period / 15 days a year (after 3 years) 5.92 hrs. per pay period / 22 days a year	Earned Based on Part-Time status and fte of position prorated	N/A
Sick time	3.23 hrs. per pay period / 12 days per year		Earned Based on Part-Time status and prorated	1hr per 35 hrs worked

- Formula to calculate how much time you will accrue between now and future date
- Accrual rate x (# of pay periods to expected date) x the fte = earning of time (vacation or sick)
- For example in 5 pay periods will earn this much more time:
  - Non Exempt FT 4.04 accrual rate x (5 pay periods) x 1.0 fte = 20.20hrs
  - Non Exempt PT 4.04 accrual rate x (5 pay periods) x .50 fte = 10.10hrs
- Vacation time is earned and use it or lose it by end of fiscal year, 8/31; unused days are converted to sick days at end of fiscal year.
- Sick days accumulate from year to year but are NOT paid out at termination

2023 Paid Holidays*

- New Year's Day
- Martin Luther King's Birthday
- Presidents Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Eve
- Christmas Day
- Floating Holiday (to be used by the end of the calendar year or lose it)

Note holidays are paid if employee is regularly scheduled to work on day of holiday, if holiday is on day employee is normally not scheduled, do not receive the holiday pay for that day.

**See Policy Handbook for full details and more time off option.*

Cost of Coverage

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Please note contributions for domestic partner coverage must be made after-tax unless they are an IRS defined tax dependent. 2023 costs shown below are bi-weekly (26/yr).

Medical	Employee Only	Employee + 1	Employee + 2 or more
BCBS PPO Plan	$74.12	$167.48	$260.83
BCBS HMO IL Plan	$38.78	$80.76	$112.70
BCBS BA HMO Plan	$36.07	$75.10	$104.81

Dental	Employee Only	Employee + 1	Employee + 2 or more
BCBS High PPO Plan	$4.45	$9.59	$17.21
BCBS Low PPO Plan	$2.11	$4.77	$9.60

Vision	Employee Only	Employee + 1	Employee + 2 or more
Vision Plan	$2.60	$4.94	$7.26

Voluntary Life costs are semi-monthly (24/yr)

Age	**<30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
Employee Rate	$0.05	$0.06	$0.07	$0.09	$0.13	$0.18	$0.32	$0.52	$0.88	$2.05
Spouse/Domestic Partner Rate	$25,000 for $6.00 / $50,00 for $12.00 semi-monthly									
Child(ren) Rate	$10,000 for $0.40 semi-monthly									

Calculation steps:

- Step 1 Determine amount of Employee coverage you wish to purchase (a multiple of your base earnings).
- Step 2 Divide the amount in Step 1 by 1,000.
- Step 3 Refer to the chart above to find your age.
- Step 4 Multiply the dollar amounts in Step 2 by the rate in Step 3 to determine your monthly premium.
- Step 5 To calculate your premium per-paycheck divide the Step 4 by 2.

Short Term Disability costs are semimonthly (24/yr)

Age	**<20**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
Employee Rate	$0.057	$0.073	$0.082	$0.089	$0.060	$0.052	$0.052	$0.061	$0.072	$0.092	$0.069	$0.068

Calculation steps:

- Step 1 Determine your annual base earnings.
- Step 2 Divide the amount in Step 1 by 52 to get your weekly earnings.
- Step 3 Multiply the dollar amount in Step 2 by 60% and round to nearest dollar.
- Step 4 Compare amount in Step 3 to $2,000, use the lesser of that or $2,000 in Step 6.
- Step 5 Refer to the chart above to find your age.
- Step 6 Multiply the result in Step 4 by the rate in Step 5 to determine your monthly premium.
- Step 7 To calculate your premium per-paycheck divide the amount in step 5 by 2.

Cost of Coverage, Continued

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Please note contributions for domestic partner coverage must be made after-tax unless they are an IRS defined tax dependent. **2023 costs shown below are semi-monthly (24/yr).**

Hospital Indemnity	Employee Only	Employee + Spouse/Domestic Partner	Employee + Child(ren)	Family
Hospital Indemnity	$9.43	$17.02	$15.05	$22.64

Accident	Employee Only	Employee + Spouse/Domestic Partner	Employee + Child(ren)	Family
Accident	$6.51	$10.28	$10.77	$14.54

Critical Illness

Age	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
Employee						
$10,000	$3.25	$4.20	$7.55	$13.75	$23.50	$42.25
$20,000	$6.50	$8.40	$15.10	$27.50	$47.00	$84.50
Spouse/Domestic Partner						
$5,000	$1.63	$2.10	$3.78	$6.88	$11.75	$21.13
$10,000	$3.25	$4.20	$7.55	$13.75	$23.50	$42.25
Child(ren)			**>26**			
25% of employee's benefit			$0.00			

2023 Plan Contacts

Plan type	Provider	Phone	Web	Policy #
Medical PPO	Blue Cross Blue Shield of Illinois	(800) 458-6024	www.bcbsil.com	PB0482
Medical BA HMO	Blue Cross Blue Shield of Illinois	(800) 892-2803	www.bcbsil.com	B50716
Medical HMO IL	Blue Cross Blue Shield of Illinois	(800) 892-2803	www.bcbsil.com	H50716
Prescription Drugs	Prime Therapeutics **Mail Order:** Express Scripts	(800) 423-1973 **Mail Order:** (833) 715-0942	www.myprime.com **Mail Order:** www.esrx.com/BCBSIL	See medical policy
Dental PPO Low	Blue Cross Blue Shield of Illinois	(800) 367-6401	www.bcbsil.com	299382
Dental PPO High	Blue Cross Blue Shield of Illinois	(800) 367-6401	www.bcbsil.com	299383
Vision	EyeMed Vision Care	(866) 804-0982	www.eyemed.com	1007533
Flexible Spending Accounts	WEX	866-451-3399 **Fax:** (866) 451-3245	www.wexinc.com **Email:** customerservice@wexhealth.com	N/A
Group Term Life/AD&D & Voluntary Life	Blue Cross Blue Shield of Illinois	(800) 348-4512	www.bcbsil.com	F023261
Short- and Long-Term Disability	Blue Cross Blue Shield of Illinois	(800) 348-4512	www.bcbsil.com	F023261
Accident, Critical Illness & Hospital Indemnity	Guardian Life	(888) 600-1600	www.guardiananytime.com	543094
Identity Theft Protection	Allstate	(800) 789-2720	www.myaip.com	N/A
Retirement Plan 403(b)	TIAA Financial Services	(800)842-2252	www.tiaa.org	N/A
Credit Union	Central Credit Union	(708) 649-6420	www.centralcu.org	N/A
Credit Union	Library of Congress Federal Credit Union	(202) 707-5852 (800) 325-2328	www.LCFCU.org **Email:** culine@LCFCU.org	N/A
Pet Benefits	Pet Benefit Solutions	(800) 891-2565	www.petbenefits.com **Email:** customercare@petbenefits.com	American Library
Employee Assistance Program (EAP)	ComPsych Guidance Resource (thru Blue Cross Blue Shield)	(866) 899-1363	www.guidanceresources.com	DISRES
Travel Assistance	Assist America (thru Blue Cross Blue Shield)	**US:** (800) 872-1414 **Other locations:** +1 (609) 986-1234	**Email:** medservices@assistamerica.com	01-AA-TRS-12201
Grisela Rodriguez, SPHR, SHRM SCP Human Resources	American Library Association	(312) 280-2467	**Email:** grodriguez@ala.com	N/A

Domestic Partner Benefit Coverage

ALA allows Domestic partners to be covered under the employee benefit plans as a dependent.

To be eligible the following must be present:

1. We have lived together for at least six months.
2. We are not married to anyone else nor have another Domestic Partner.
3. We are at least 18 years of age and mentally competent to consent to contract.
4. We reside together in the same residence and intend to do so indefinitely.
5. We have an exclusive mutual commitment similar to that of marriage.
6. We are jointly responsible for each other's common welfare and share financial obligations.
7. We can provide all or some of the types of documentation indicated below if requested.

Or, present registration with state or local government domestic partner registry.

To get a Domestic Partner covered on benefits, first complete a Domestic Partner Affidavit and Provide proof of at least 3 for the following:

- Joint mortgage or lease
- Joint ownership of motor vehicle
- Joint checking account
- Joint credit account
- Designation of Domestic Partner as beneficiary for life insurance and retirement contract
- Designation of Domestic Partner as primary beneficiary in employee's or insured's will
- Durable property and health care powers of attorney

Or, present registration with state or local government domestic partner registry.

Tax Treatment of Domestic Partner Benefits

The value of the benefits provided for domestic partners is taxable by the IRS. The fair market value for domestic partner coverage is calculated in the following manner based on the benefits an employer contributes to on behalf of the employee and dependent, most common are medical and/or dental plans elected by the employee. The appropriate taxes will be withheld from every payroll check.

Calculate value taxed

a) Determine the annual employer premium for Single coverage less Single +1.
b) Determine the difference in employee premium for Single coverage less Single+1.
c) The combination is considered imputed income and taxable

Sample calculations:

Cost of Medical Coverage	Employee	ALA
Single	$74.12	$342.99
Single +1	$167.48	$774.99

	Singe less Single + 1		
Employee costs	$167.48 - $74.12	=	$93.36
Employer costs	$774.99 - $342.99	=	$432.00
	Total imputed income and taxable		$525.36

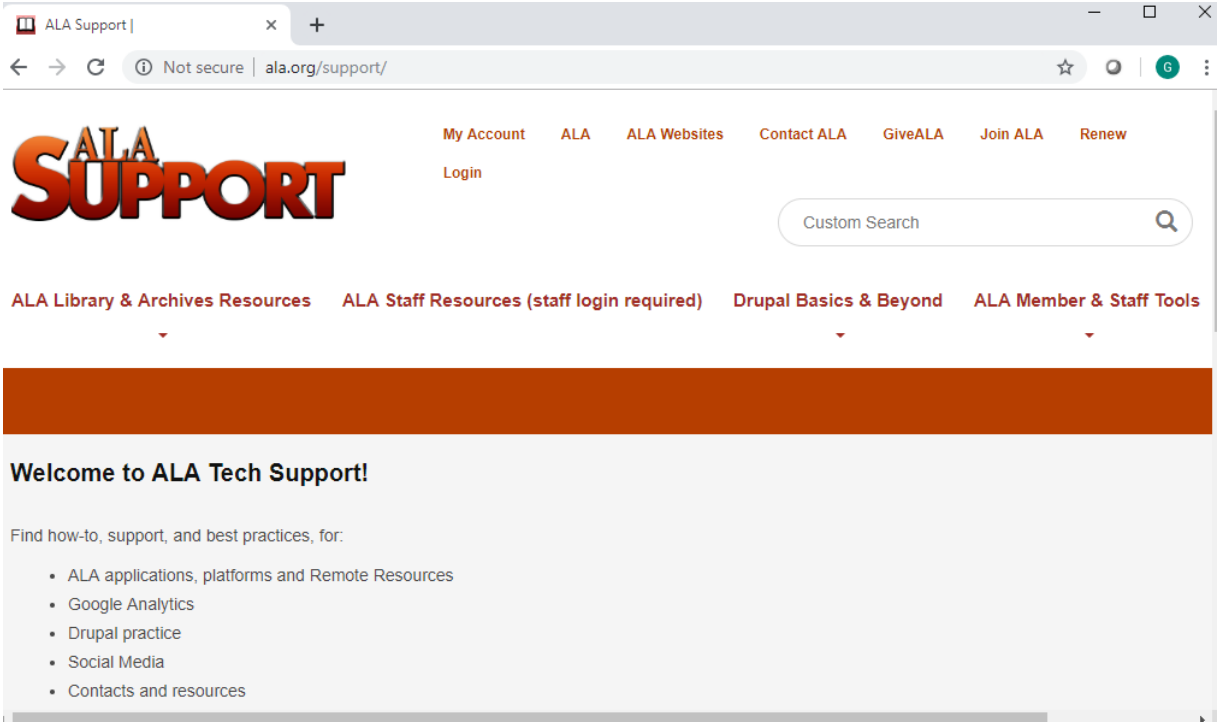
Contact Human Resources for Affidavit and more information.

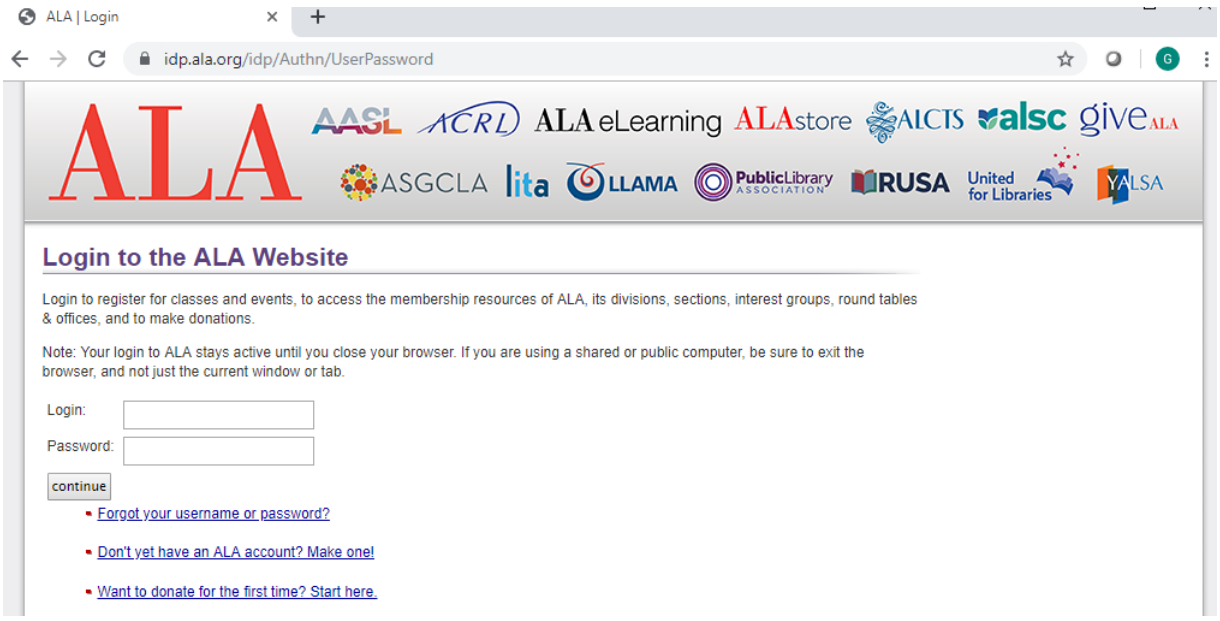
Support Site Navigation

ALA has a section of the website that has resources for staff use.

Go to: www.ala.org/support

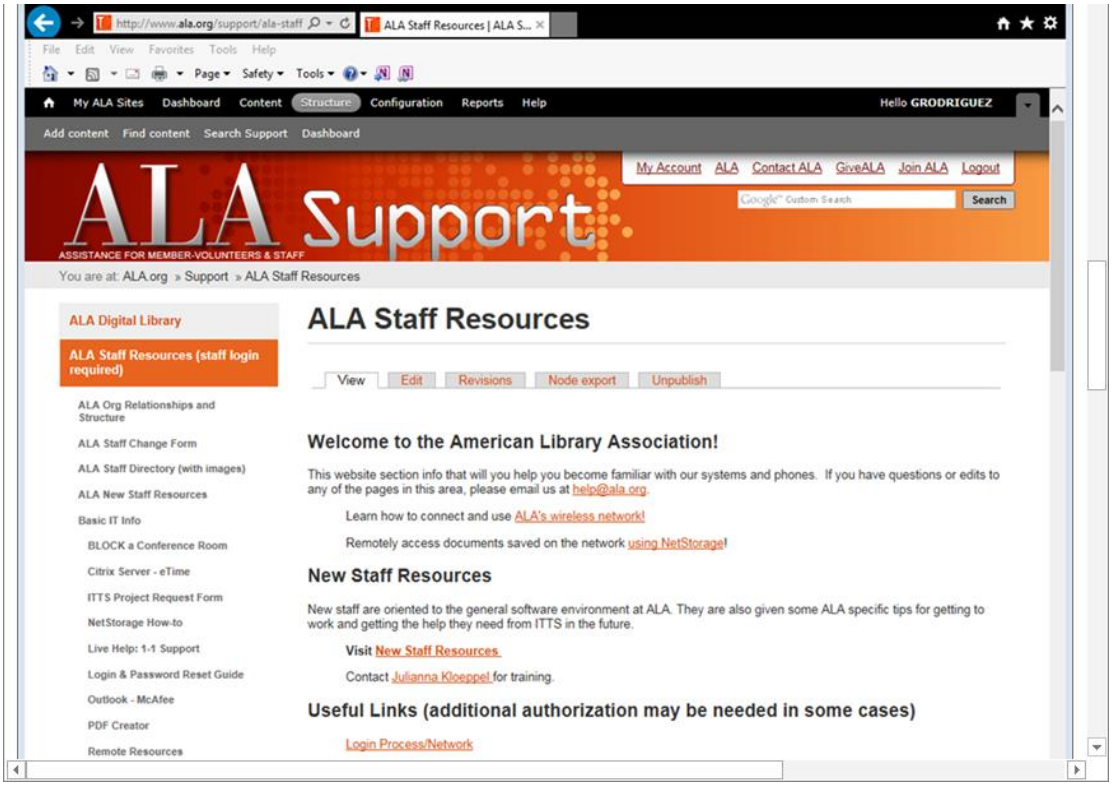
Login: (IT will provide login and password to access)



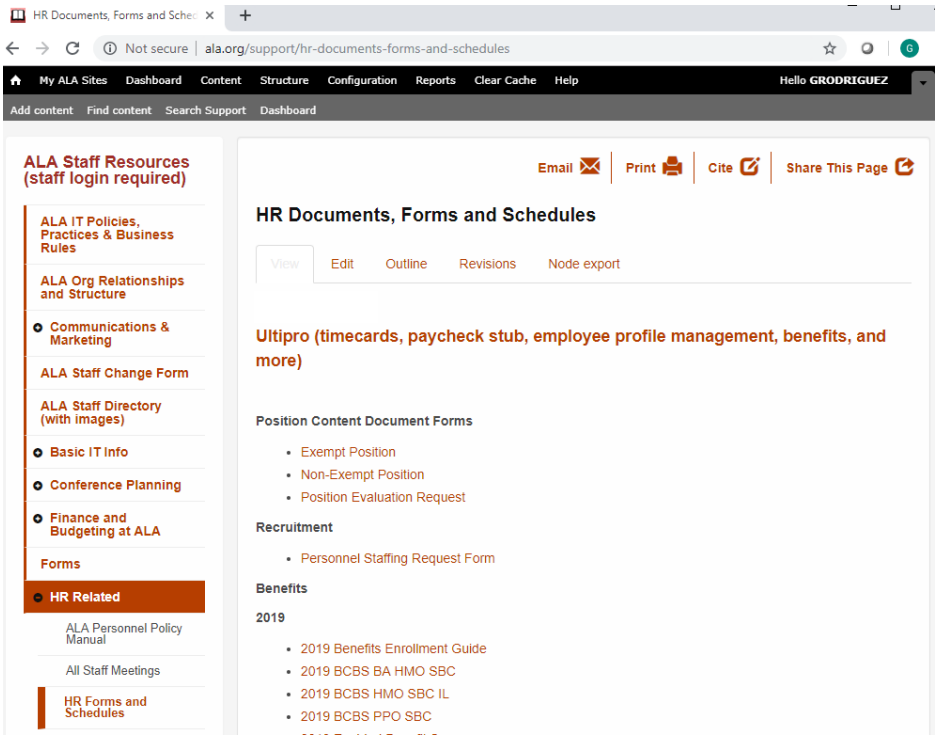


Support Site Navigation, Continued

Go to Staff Resources:



Navigate to HR Related:

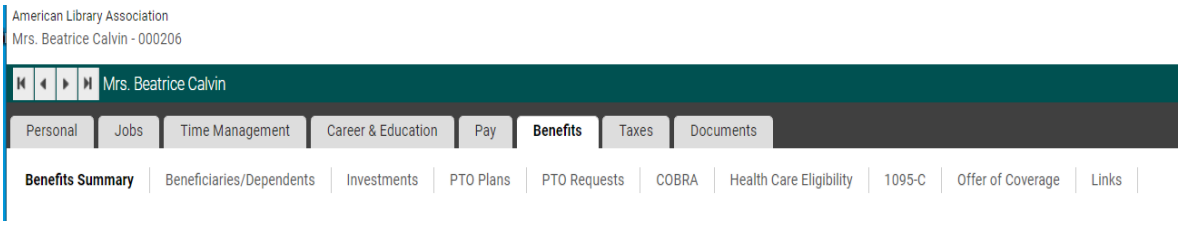


Look for the information or document you need.

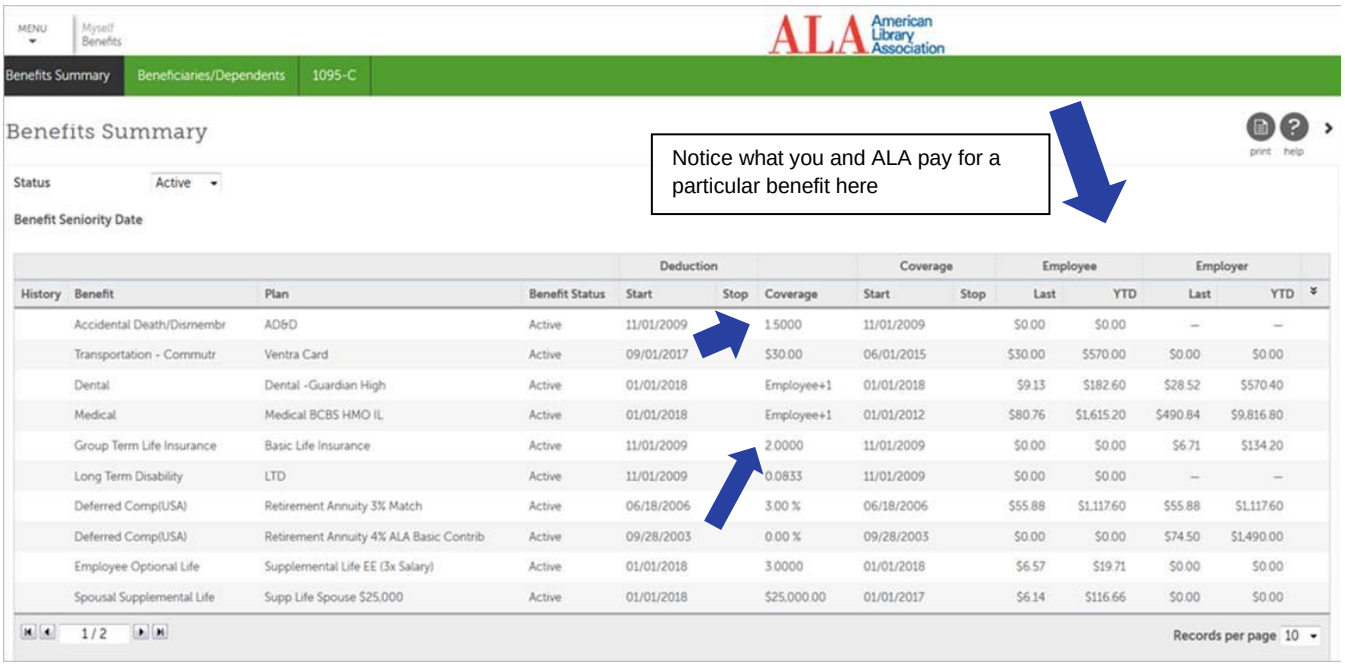
UKG Data System

How do I see my benefits?

Log into UKG and navigate to the Benefits Summary to see your benefits enrollment. See the different tabs in UKG, select "Benefits" to see the plans you are enrolled in like the image below.



Benefits Summary



				Deduction			Coverage		Employee		Employer	
History	Benefit	Plan	Benefit Status	Start	Stop	Coverage	Start	Stop	Last	YTD	Last	YTD
	Accidental Death/Dismembr	AD&D	Active	11/01/2009		1.5000	11/01/2009		$0.00	$0.00	–	–
	Transportation - Commutr	Ventra Card	Active	09/01/2017		$30.00	06/01/2015		$30.00	$570.00	$0.00	$0.00
	Dental	Dental -Guardian High	Active	01/01/2018		Employee+1	01/01/2018		$9.13	$182.60	$28.52	$570.40
	Medical	Medical BCBS HMO IL	Active	01/01/2018		Employee+1	01/01/2012		$80.76	$1,615.20	$490.84	$9,816.80
	Group Term Life Insurance	Basic Life Insurance	Active	11/01/2009		2.0000	11/01/2009		$0.00	$0.00	$6.71	$134.20
	Long Term Disability	LTD	Active	11/01/2009		0.0833	11/01/2009		$0.00	$0.00	–	–
	Deferred Comp(USA)	Retirement Annuity 3% Match	Active	06/18/2006		3.00 %	06/18/2006		$55.88	$1,117.60	$55.88	$1,117.60
	Deferred Comp(USA)	Retirement Annuity 4% ALA Basic Contrib	Active	09/28/2003		0.00 %	09/28/2003		$0.00	$0.00	$74.50	$1,490.00
	Employee Optional Life	Supplemental Life EE (3x Salary)	Active	01/01/2018		3.0000	01/01/2018		$6.57	$19.71	$0.00	$0.00
	Spousal Supplemental Life	Supp Life Spouse $25,000	Active	01/01/2018		$25,000.00	01/01/2017		$6.14	$116.66	$0.00	$0.00

This 1.5 and 2.0 are the multiples of salary level ALA provides you with, AD&D and Basic Life Insurance.

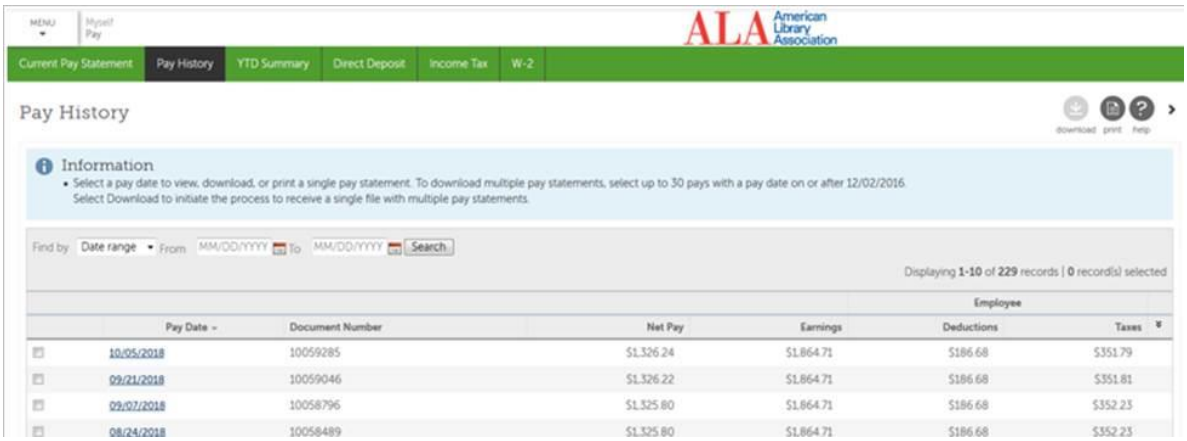
Other lines show your selected benefit coverage level, Single, Single+1, Single+2(or more), or Family.

Deferred Comp, this is your 403b plan if you are contributing and what ALA is contributing to your account.

UKG Data System, Continued

How to see benefits and deductions on my check?

Navigate to the pay summary to see your pay information.



MENU | Myself Pay

ALA American Library Association

Current Pay Statement | Pay History | YTD Summary | Direct Deposit | Income Tax | W-2

Pay History

download print help

Information

- Select a pay date to view, download, or print a single pay statement. To download multiple pay statements, select up to 30 pays with a pay date on or after 12/02/2016. Select Download to initiate the process to receive a single file with multiple pay statements.

Find by Date range From MM/DD/YYYY To MM/DD/YYYY Search

Displaying 1-10 of 229 records | 0 record(s) selected

	Pay Date	Document Number	Net Pay	Earnings	Employee Deductions	Taxes
	10/05/2018	10059285	$1,326.24	$1,864.71	$186.68	$351.79
	09/21/2018	10059046	$1,326.22	$1,864.71	$186.68	$351.81
	09/07/2018	10058796	$1,325.80	$1,864.71	$186.68	$352.23
	08/24/2018	10058489	$1,325.80	$1,864.71	$186.68	$352.23

MENU | Myself Pay

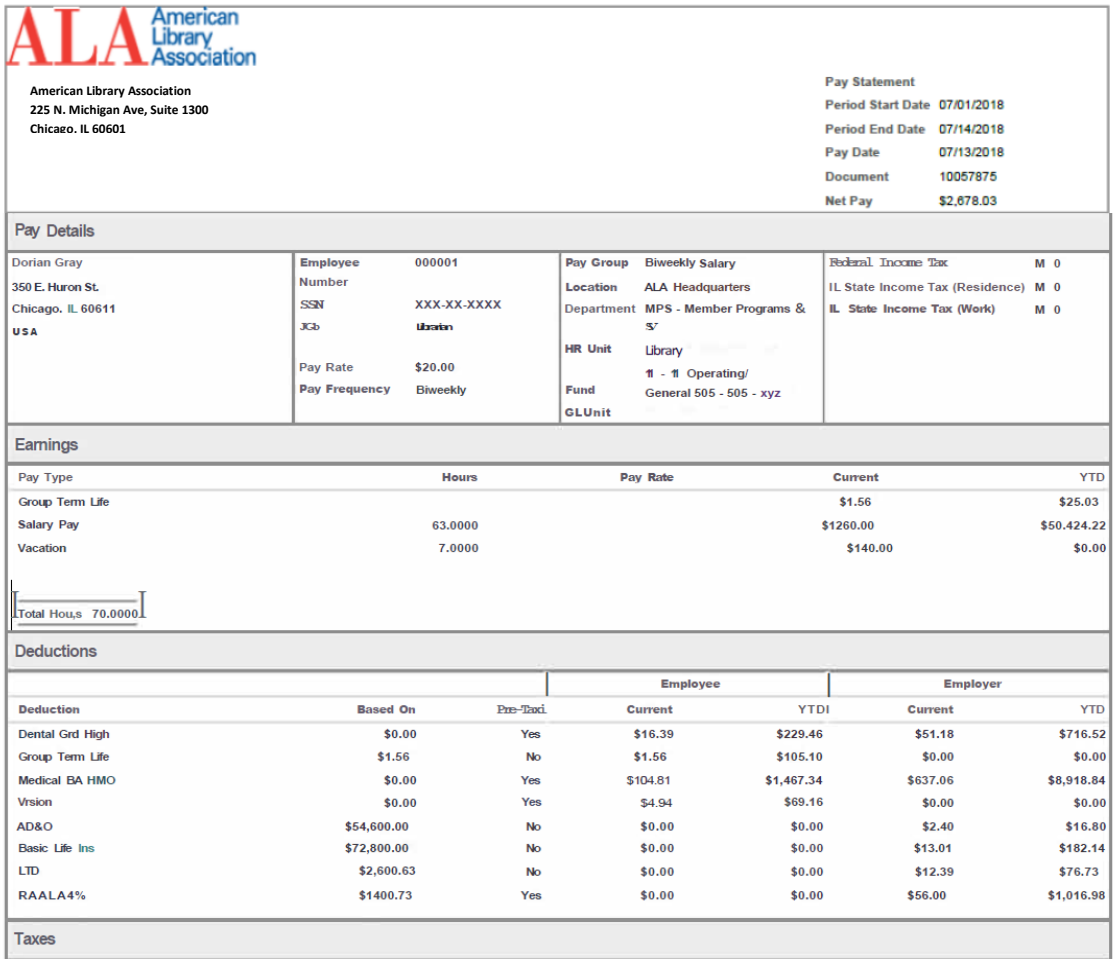
ALA American Library Association

Current Pay Statement | Pay History | YTD Summary | Direct Deposit | Income Tax | W-2

Pay Statement

download print help

This is a statement of earnings and deductions. This pay statement is non-negotiable.



ALA American Library Association

American Library Association
225 N. Michigan Ave, Suite 1300
Chicago, IL 60601

Pay Statement
Period Start Date 07/01/2018
Period End Date 07/14/2018
Pay Date 07/13/2018
Document 10057875
Net Pay $2,678.03

Pay Details

Dorian Gray 350 E. Huron St. Chicago, IL 60611 USA	Employee Number 000001 SSN XXX-XX-XXXX JGb Librarian Pay Rate $20.00 Pay Frequency Biweekly	Pay Group Biweekly Salary Location ALA Headquarters Department MPS - Member Programs & S7 HR Unit Library Fund 11 - 11 Operating/ General 505 - 505 - xyz GLUnit	Federal Income Tax M 0 IL State Income Tax (Residence) M 0 IL State Income Tax (Work) M 0

Earnings

Pay Type	Hours	Pay Rate	Current	YTD
Group Term Life			$1.56	$25.03
Salary Pay	63.0000		$1260.00	$50.424.22
Vacation	7.0000		$140.00	$0.00
Total Hours	70.0000			

Deductions

Deduction	Based On	Pre-Tax	Employee Current	Employee YTD	Employer Current	Employer YTD
Dental Grd High	$0.00	Yes	$16.39	$229.46	$51.18	$716.52
Group Term Life	$1.56	No	$1.56	$105.10	$0.00	$0.00
Medical BA HMO	$0.00	Yes	$104.81	$1,467.34	$637.06	$8,918.84
Vrsion	$0.00	Yes	$4.94	$69.16	$0.00	$0.00
AD&O	$54,600.00	No	$0.00	$0.00	$2.40	$16.80
Basic Life Ins	$72,800.00	No	$0.00	$0.00	$13.01	$182.14
LTD	$2,600.63	No	$0.00	$0.00	$12.39	$76.73
RAALA4%	$1400.73	Yes	$0.00	$0.00	$56.00	$1,016.98

Taxes

Important Notices

Health plan notices

These notices must be provided to plan participants on an annual basis and are available at the end of this guide:

Medicare and You	Describes Medicare requirements	Page 41
Medicare Part D Notice	Creditable coverage notice. Describes options to access prescription drug coverage for Medicare eligible individuals	Page 42
COBRA Health Insurance Continuation Rights	Describes you and/or your dependent's right to continue coverage after you lose eligibility under the terms of our health plan.	Page 45
Women's Health and Cancer Rights Act	Describes benefits available to those that will or have undergone a mastectomy	Page 46
Newborns' and Mothers' Health Protection Act	Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery	Page 47
HIPAA Notice of Special Enrollment Rights	Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment	Page 47
HIPAA Notice of Privacy Practices	Describes how health information about you may be used and disclosed	Page 47
Notice of Choice of Providers	Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one	Page 49
Michelle's Law	Describes right to extend dependent medical coverage during student leaves	Page 50
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)	Describes availability of premium assistance for Medicaid eligible dependents	Page 50
New Health Insurance Marketplace Coverage Options and Your Health Coverage	Describes information about the Marketplace Exchanges, the premium tax credit (if applicable), and the impact of choosing coverage through the Marketplace Exchange instead of through an employer.	Page 55

Medicare and You

All ALA employees, spouses or domestic partners should be aware of Medicare requirements. Anyone who becomes Medicare eligible is required to enroll according to the guidelines listed below. Employees with any spouse or domestic partner on their ALA health plans who become Medicare eligible are also required to enroll in Medicare. The ALA medical insurance carrier and Medicare will coordinate coverage if necessary. **In instances where Medicare would be a primary payer, even if the individual is not enrolled in Medicare, the insurance company will only pay what they would if the person was enrolled in Medicare.**

What's Medicare?

- Medicare is the federal health insurance program for people who are 65 or older

When can I sign up?

- 3 months before 65th birthday

What should I enroll in?

- Enroll in Part A (free to you)
- While still working and covered under a group health plan you don't need Medicare Part B
- When you retire you will need to enroll in Part B (a few months before you leave ALA you should contact Medicare about your plans so you can add Medicare Part B and avoid penalties for enrolling late)
- If you are on the ALA Health plan as an employee or retiree you have prescription coverage so you don't need Medicare Part D, see the annual Notice of Creditable Coverage describing the plan prescription coverage.

What do I need to do to apply?

- Prepare to apply online (can take 10 minutes), see the checklist for applying for Medicare online http://www.ssa.gov/hlp/isba/10/isba-checklist.pdf

What website do I use to apply online?

- https://secure.ssa.gov/iClaim/rib

The Parts of Medicare services:

- **Medicare Part A** (Hospital Insurance) inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care
- **Medicare Part B** (Medical Insurance) certain doctors' services, outpatient care, medical supplies, and preventive services
- **Medicare Part C** (Medicare Advantage Plans) plan offered by a private company that contract with Medicare to provide you with all your Part A and Part B benefits
- **Medicare Part D** (prescription drug coverage) prescription drug coverage. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information see Medicare.gov

Medicare Part D Notice of Creditable Coverage

Important Notice from American Library Association about your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current American Library Association coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under American Library Association is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

CMS Form 10182-CC Updated April 1, 2011According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

If you do decide to join a Medicare drug plan and drop your American Library Association prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with American Library Association and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through American Library Association changes. You also may request a copy of this notice at any time.

- Blue Cross Blue Shield of Illinois (855) 649-9653

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

CMS Form 10182-CC Updated April 1, 2011According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Date:	10/12/2022
Plan Administrator:	American Library Association Grisela Rodriguez, SPHR, SHRM-SCP Human Resources
Address:	225 N. Michigan Ave, Suite 1300 Chicago, IL 60601
Phone:	312-280-2467
Email:	grodriguez@ala.org

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COBRA Health Insurance Continuation Rights

- Our group health plan is required to give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under our Plan.
- Qualified beneficiaries may include the employee covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.
- Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment.

Elect COBRA Continuation Coverage

- To elect continuation coverage, you must complete the election form within 60 days of the date of the offer letter or your last day of coverage, whichever is later.
- Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse or child(ren) may elect continuation coverage even if the employee does not.

Failure to continue your group health coverage will affect your future rights under federal law.

- You can lose the right to avoid preexisting condition exclusions by other group health plans if you have a gap in health coverage of 63 days or more.
- You will lose the guaranteed right to purchase individual health coverage without a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you.
- You have the right to request special enrollment in another group health plan for which you are eligible within 30 days after the end of continuation coverage.

Maximum Coverage Period

The maximum coverage period is based on the qualifying event causing a loss of eligibility.

- End of employment or reduction in hours allows coverage continuation for up to 18 months.
- The employee became eligible for Medicare less than 18 months prior to the COBRA qualifying event; continuation coverage for qualified beneficiaries lasts until 36 months after the date of Medicare eligibility.
- Employee's death, divorce or legal separation, or the employee's becoming entitled to Medicare benefits allows coverage continuation for up to a total of 36 months.
- A dependent child ceasing to be a dependent under the terms of the plan may be eligible for coverage continuation for up to 36 months.

COBRA Termination

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time
- A qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary
- A qualified beneficiary first becomes entitled to Medicare benefits after electing continuation coverage
- The employer ceases to provide any group health plan for its employees
- For any reason the Plan would terminate coverage of an active employee or beneficiary not receiving continuation coverage (such as fraud)

Continuation Extension

- If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs.
- Notify the Benefits Division of a disability or a second qualifying event in order to extend the period of continuation coverage.
- Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

- An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled.
- The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

- Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies.
- If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

- Second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.
- Events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.
- An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage.
- The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.
- If you want to extend your continuation coverage notify the Plan within 60 days after a second qualifying event occurs.

COBRA Continuation Coverage Payments

- Continuation coverage costs 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.
- Payments for continuation coverage should be made payable to the COBRA Administrator, address and other information will be provided with enrollment materials.

Initial Payment

- Your benefits will not be reinstated until payment is received.
- You must make your first payment for continuation coverage no later than 45 days after the date of your election. The date of your election is considered the date the Election Notice is post-marked, if mailed.
- If you have not paid in full after 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

Periodic Payments

- You will be required to make monthly payments for each subsequent coverage period. Under the Plan, each of these periodic payments for continuation coverage is due on the 1st day of the month for that coverage period.
- You will be given a grace period of 30 days after the first day of the coverage to make each periodic payment.
- If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (312) 280-2467.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (312) 280-2467.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in American Library Association's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in American Library Association's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in American Library Association's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

HIPPA Notice of Privacy Practices

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

This notice is intended to inform you of the privacy practices followed by AMERICAN LIBRARY ASSOCIATION (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. The plan requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

***As permitted or required by law*.** We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization*.* When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates*.* We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of AMERICAN LIBRARY ASSOCIATION for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy*.* In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures*.* You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your

presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact Human Resources

Complaints If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr or further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Notice of Choice of Providers

The Blue Cross and Blue Shield of Illinois Blue Advantage HMO and HMO of Illinois plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan designates a primary care provider automatically, include highlighted text following: Until you make this designation, [name of plan] designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at (312) 280-2467.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Cross and Blue Shield of Illinois or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to

comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator at (312) 280-2467.

Michelle's Law

The American Library Association Employee Benefits Plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify the plan administrator in writing at grodriguez@ala.org as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – **Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – **Medicaid**
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources, Grisela Rodriguez at 312-280-2467 or grodriguez@ala.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name	4. Employer Identification Number (EIN)
American Library Association	36-2166947
5. Employee Address	**6. Employer Phone Number**
225 N. Michigan Ave, Suite 1300	312-280-2467

7. City	8. State	9. ZIP Code
Chicago	IL	60601

10. Who can we contact about employee health coverage at this job?
Grisela Rodriguez, Human Resources

11. Phone Number (if different from above)	12. Email Address
312-280-2467	Grodriguez@ala.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:

    Employee is a regular position with at least .50 FTE

  - ☒ Some employees. Eligible employees are:

    Employee is a regular position with at least .50 FTE

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Dependents of employees in a regular position with at least a .50 fte, employee must enroll to offer coverage to dependents.

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

[x] **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 1st of month following 30 days of employment (mm/dd/yyyy) (Continue)
[ ] **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
[x] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $36.07
b. How often? [ ] Weekly [x] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? No change for 2023
[ ] Employer won't offer health coverage
[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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Notice of Electronic Distribution of Benefits Documents

Dear Plan Participant:

As a plan participant in American Library Association (ALA) benefit plans you are entitled to information about your benefits a comprehensive description of your right and responsibilities under the group benefit plans.

Electronic copies of all plan documents including the Summary Plan Description (SPDs), certificates, applications, detailed information and more are located on our website under support site (login required) for your reference: http://www.ala.org/support/hr-documents-forms-and-schedules.

To ensure you fully understand the benefits available to you and your rights and responsibilities as a plan participant, it is important that you familiarize yourself with the information contained within the SPDs and let us know if you have any questions.

If you would like to receive a copy of any of these documents let Human Resources know and you will receive a copy free of charge.

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FAQs

When will changes become effective?

- Changes made during Open Enrollment to medical, dental, vision, optional life insurance, optional short-term disability and flexible spending account plans become effective on January 1st, provided all necessary requirements are completed.
- Changes may require completing additional forms; if the necessary forms are not completed and submitted on time, changes will not be applied.

What forms do I need to complete if I am making changes?

- If you make any plan changes to life insurance or disability coverage you will need to complete change forms available in UKG when you make your election, or Contact Human resources.
- If you choose an HMO Medical Plan remember to select a medical group and a primary care physician, otherwise your enrollment will not be accepted by BCBS, page 10 and 11 have instruction on how to find HMO doctor and information needed.

What forms do I need to complete if I am electing the Optional STD?

- If you are electing the Optional Short-Term Disability benefit, you will need to complete the Blue Cross Blue Shield of Illinois STD enrollment form found in UKG when you make your election, or contact Human Resources.

Where do I find these forms?

- As you complete your enrollment online, you will be prompted to download the necessary forms to complete your elections;
- Or, Human Resources; contact Grisela Rodriguez, at 312-280-2467 or grodriguez@ala.org for forms.

When are the forms due and where do I return them?

- All forms are due by the last day of Open Enrollment, to Grisela Rodriguez in Human Resources.

If I change my name what do I need to do to update it with ALA?

- Once you update your social security card, bring us a copy of the new card and we can change it on your employee records and with the insurance companies. You will need to contact TIAA directly to change your name on your retirement account.

How can I tell what benefits I enrolled in?

- Look at your benefits screen in UKG, see page 38 and 39.

How do I see what I am being charged for my benefits?

- Look at your paycheck in UKG, go to the Pay tab and select the most recent check, see page 39.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report benefits. In case of discrepancy between the Guide and the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

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2023 Benefit Election Medical Waiver Form

_____
Print Name

Initial below:

_____I acknowledge that the American Library Association (ALA) has offered me medical coverage that, according to Patient Protection and Affordable Care Act ("ACA") is considered affordable minimum essential coverage.

_____I have decided not to take advantage of this offer.

I am waiving coverage because:

_____ I am covered under another plan _____

I understand that if I lose coverage under this other plan, I can enroll in the ALA plan if I provided written notice that the coverage is ending within 30 days of losing the other coverage otherwise I will have to wait for open enrollment.

_____ I am waiving coverage because _____

_____I understand that if I have a life change event such as gain or lose a new dependent through marriage, divorce, birth, or adoption I may make a change consistent with the life event within 30 days. If I miss the 30-day enrollment deadline, I realize open enrollment will be the next time I can make any changes.

_____ I understand that if I decline coverage offered from an employer that is considered affordable and minimum essential under the ACA, I will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

_____I understand that, in compliance with the ACA, I have an individual responsibility and if I refuse health coverage from an employer and I do not obtain coverage on my own, I will be subject to a penalty.

_____ I have read the above and I understand the consequences of my waiver of coverage.

_____ _____
Print Name Signature

_____
Date

_____ _____ _____
Human Resources Name Signature Date

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ALA American Library Association

2023 Benefit Election Form

Name_____Date of Hire_____Effective_____

Select your benefits below. **You** must enroll to insure dependents. Qualifying dependents can be covered up to age 26 or age 30 if a military veteran.

Benefit Plans	Options	Single	Single+1	Single+2	Enroll/ Waive	Per Pay Period Cost Pre-Tax	Per Pay Period Cost Post-Tax
Medical	**Blue Cross Blue Shield**						
	PPO	$74.12	$167.48	$260.83	_____	$_____	
	*HMO Illinois	$38.78	$80.76	$112.70	_____	$_____	
	*Blue Advantage HMO	$36.07	$75.10	$104.81	_____	$_____	
Only available in Illinois							
Dental	**Blue Cross Blue Shield**						
	High	$4.45	$9.59	$17.21	_____	$_____	
	Low	$2.11	$4.77	$9.60	_____	$_____	
Vision	**EyeMed**						
	Vision	$2.60	$4.94	$7.26	_____	$_____	
FSA	**WEX**	PPD Ded	#ppds to end of year	Total to end of year			
	Healthcare Flex Spending				_____	$_____	
	Dependent Care Flex Spending				_____	$_____	
Life/AD&D	**Blue Cross Blue Shield**						
	Life Insurance	2x salary			Enroll	$0 ALA Provided	
	AD&D	1.5x salary			Enroll	$0 ALA Provided	
Voluntary Life**	**Blue Cross Blue Shield**						
	Supplemental Life	_____	x salary		_____		$_____
	Spouse/Domestic Partner Life	$25,000 of coverage $6.00	$50,000 of coverage $12.00	****	_____		$_____
	Child(ren) Life	$10,000 of coverage $0.40			_____		$_____
Voluntary Short Term Disability**	**Blue Cross Blue Shield**				_____		$_____
Long Term Disability	**Blue Cross Blue Shield**				Enroll	$0 ALA Provided	

See Next Page for More Options

ALA American Library Association

2023 Benefit Election Form

Benefit Plans	Options			Enroll/ Waive	Per Pay Period Cost	
					Pre-Tax	Post-Tax

Plans Options Continued, Cost semi-monthly

	Single		Family		
Allstate Identity Protection**	$4.98		$8.98	_____	$ _____
Guardian Critical Incidents**	Single	EE+SP/ EE+CH	Family		
Hospital	$9.43	$17.02/ $15.05	$22.65	_____	$ _____
Accident	$6.51	$10.28/ $10.77	$14.54	_____	$ _____

Critical Illness	(See cost section for age rates)			
Options: Employee only -or Employee & Spouse/Domestic Partner -or Employee, Spouse/Domestic Partner, and Child(ren) -or Employee and Child(ren) (Spouse/Domestic Partner can only have 50% of what employee has Child(ren) can be up to 25% of Employee, to age 26)	$20,000 Employee	_____	$ _____
	$10,000 Employee	_____	$ _____
	$10,000 Spouse/Domestic Partner	_____	$ _____
	$5,000 Spouse/Domestic Partner	_____	$ _____
	$5,000 Child	_____	$0.00
	$2,500 Child	_____	$0.00

	$ _____	$ _____
Total per Pay period	$ _____	

***deduction is semi-month otherwise by weekly*

*****evidence of insurability required*

_____I understand my election can only be changed during the open enrollment period which takes plan once each year. I want my contribution to be deducted from my check as indicated above as allowed under Section 125 of the Internal Revenue Code.

_____I Acknowledge that should I choose to retain this election in future year, my contribution may increase and I hereby authorize the increase in my payroll deductions.

Signature_____ Date_____

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Revised 10/13/2022