Guide to Your

2025 Benefits

JULY 1, 2025 – JUNE 30, 2026

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Welcome to the Lockport Area Benefit Plan Benefits Program

Lockport Township High School is pleased to present this overview of your employee benefits. We offer a variety of benefits to help you protect your health, your family, and your way of life.

Your benefits are a valuable part of your compensation package. Please take the time to review this information carefully, along with the materials provided by the insurance carriers, and keep it handy for future reference. You may also contact the insurance carriers directly if you have any questions; their phone numbers and websites are listed under the Contact Information section.

This booklet is intended to provide only the highlights of your benefits; see your plan documents for full details. If any conflict ever arises between this booklet and the actual plan document, the terms of the plan document will govern in all cases. Lockport Area Benefit Plan reserves the right to change, modify, or terminate the benefit plans at any time. This booklet is not a contract for purposes of employment or payment of benefits.

General Information

Who Is Eligible

You may enroll in the Lockport Area Benefit Plan if you are a regular full-time employee and you have met the requirements of your working group agreement.

You may also enroll your eligible dependents for benefits. Generally, your eligible dependents are:

- Your legal spouse, as defined by federal law.
- Your civil union spouse.
- Your children up to age 26. This includes your natural children, stepchildren, adopted children, and children for whom you are the legal guardian.
- Your unmarried children may be covered under the medical, dental, and vision plans up to age 30 if they:
  - Live within the state of Illinois; and
  - Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
  - Have received a release or discharge other than a dishonorable discharge.
- Your mentally or physically disabled children over age 26 (if they depend on you for support). You will be required to provide appropriate documentation of their disability.

When Coverage Starts

You must sign up for benefits within 30 days of becoming eligible.

New Employees. Your coverage becomes effective on your Date of Hire.

Open Enrollment. If you sign up for benefits during open enrollment, your coverage becomes effective July 1st.

Changing Your Coverage During the Year

Once you enroll for coverage, you may not change or cancel your benefits until the next open enrollment period unless you have a "qualifying event," such as marriage, divorce, birth or adoption of a child, death of a dependent, or certain events that affect your dependent's insurance coverage (for example, your spouse losing his or her job). If you experience a qualifying event, you must contact your Benefits Department to change your coverage within 30 days of the event.

Medical

BlueCross BlueShield of Illinois

Lockport Area Benefit Plan offers comprehensive medical plan coverage through Blue Cross Blue Shield of Illinois. Availability of plans is based on your employment group and length of service.

- Blue Choice Options PPO Plan
- Blue Choice Options HSA Compatible Plan
- HMO Plan

How Your Blue Choice Options Plans Work

A preferred provider organization (PPO) is a network of doctors and health care facilities that provide services to plan members at discounted rates. You can go to any doctor you like within the Blue Choice Options (BCO) network, including specialists, without a referral. In-network preventive care is covered in full.

You still have access to the Traditional BCBS PPO network with this plan. The Blue Choice Options PPO has two sets of in-network benefits. When searching for providers, you will use "Blue Choice Options [BCO]" network. Your deductible, copays and coinsurance are the lowest if you use a Tier 1: BCO Provider. The deductibles and out-of-pocket maximums cross-accumulate between Tier 1 and Tier 2 which will allow you to limit total out-of-pocket expenses when you stay in-network.

Tier 1 includes providers in the BCO Network which is a smaller network with some of these commonly used hospitals: Advocate, Loyola, NorthShore (Glenbrook, Highland Park, Evanston, Skokie), Northwestern, Rush University Medical Center, Rush Oak Park Hospital and Northwest Community.

Tier 2 includes providers under the Traditional BCBS PPO network, including: Lurie Children's Hospital, SouthShore Hospital, and University of Chicago Medical Center.

If you go to an out-of-network provider, the plan will pay benefits based on Medicare reimbursement rates for a particular health care service in your geographic area. **If your out-of-network provider charges more than the amount covered by the plan, you will have to pay all charges over that amount.**

How an HSA Compatible Plan Works

Your HSA Compatible plan utilizes the same network as the traditional PPO plan. In-Network preventive care is covered in full (not subject to the deductible), but you must pay the full deductible before the plan pays for any other medical services.

Unlike a traditional PPO, this type of plan has no copay schedule for prescription drugs. You must pay the full discounted price for your prescriptions (and medical care) until you have met the deductible. After you have paid the deductible, you will pay coinsurance for your prescription drug and medical expenses until you reach the out-of-pocket limit.

In addition, this plan allows for you to open a Health Savings Account (HSA) to help pay for your medical expenses and prescription drugs while you are still paying your deductible. See page 11 for more information about HSAs.

If you go to an out-of-network provider, the plan will pay benefits based on Medicare reimbursement rates for a particular health care service in your geographic area. ***If your out-of-network provider charges more than the amount covered by the plan, you will have to pay all charges over that amount.***

How the HMO Plan Works

A health maintenance organization (HMO) is a network of doctors and health care facilities that closely manage your medical care in an effort to control cost.

When you enroll in the HMO, you (and each of your enrolled dependents) must choose a primary care physician (PCP) from the Blue Advantage HMO Network. That physician will coordinate all of your medical care, including any referrals to a specialist that may be necessary. Women may go directly to an OB/GYN in their PCP's medical group without a referral. **Unless it's an emergency, you must receive all of your medical care within the HMO network—and under your PCP's direction—or the plan will not cover it.**

The Medical Plan Comparison charts on pages 5-7 show the key benefits for each of the medical plans.

Availability of Summary Health Information

To help you make an informed choice, Blue Cross Blue Shield of Illinois makes available a Summary of Benefits and Coverage (SBC), for each plan option. The SBC summarizes important information about the plan's benefits, limitations and exclusions, in a standard format. It is a great resource as you compare your medical plan options, and is available from Blue Cross Blue Shield of Illinois. You may also request a copy by contacting the Business Office.

See page 12 for a glossary of medical plan terms.

Medical Plan Comparison

Plan Name	Blue Choice Options PPO		
Network	**Blue Choice Options Network**	**BCBS PPO Network**	**Out-of-Network**
Annual Deductible	$750/person $1,500/family	$1,500/person $3,000/family	$2,000/person $4,000/family
Deductible Type	Embedded, Blue Choice Options Network and BCBS PPO Network Cross Apply		
Coinsurance (plan pays after deductible is met)	80%	70%	50%
Annual Out-of-Pocket Limit (includes copays, deductible, and coinsurance)	$2,000/person $4,000/family	$3,000/person $6,000/family	$8,000/person $16,000/family
Prescription Drug Out-of-Pocket Limit	$1,000/person $2,000/family		
Preventive Care (includes routine physical exams, well-child care, women's preventive health services, and routine diagnostic tests)	Covered in full		50% after deductible
Covered Services	**What You Pay**		
Physician Office Visits	20% after deductible	30% after deductible	50% after deductible
Specialist Office Visits	20% after deductible	30% after deductible	50% after deductible
Specialist Referral Required	No	No	No
Inpatient Hospital Services	20% after deductible	30% after deductible	50% + $100 after deductible
Outpatient Services	20% after deductible	30% after deductible	50% after deductible
Urgent Care	20% after deductible	30% after deductible	50% after deductible
Emergency Room Care	$250 copay		
Pharmacy – Retail (up to **30**-day supply) • Generic Drugs • Preferred Brand • Non-Preferred Brand • Specialty	 $10 copay $40 copay 20% to $100 max 20% to $125 max		$10 copay* $40 copay* 20% to $100 max* 20% to $125 max*
Pharmacy – Mail Order (up to **90**-day supply) • Generic Drugs • Preferred Brand • Non-Preferred Brand	 $20 copay $80 copay 20% to $200 max		Not covered

** For out-of-network pharmacy, you are responsible for an additional 25% of the eligible amount.*

Medical Plan Comparison

Plan Name	Blue Choice Options PPO w/HSA Plan		
Network	**Blue Choice Options Network**	**BCBS PPO Network**	**Out of Network**
Deductible			
• Individual	$1,650	$2,000	$3,000
• Family	$3,300	$4,000	$6,000
Deductible Type	Aggregrate* Blue Choice Options Network and PPO Network Cross Apply		
Inpatient Hospital	Ded then 20%	Ded then 30%	Ded then 50%
Outpatient Hospital	Ded then 20%	Ded then 30%	Ded then 50%
Coinsurance	20%	30%	50%
Out-of-Pocket Max. (Including Deductible)			
• Individual	$3,200	$3,500	$6,000
• Family	$6,400	$7,000	$12,000
Prescription Drug Out-of-Pocket Limit	Prescription are applied toward the medical out-of-pocket limit		
LTHS HSA Contribution	Single: $400 / Family: $1,050 See page 11 or your Work Agreement for details		
Doctor Co-Pay	Ded then 20%	Ded then 30%	Ded then 50%
Specialist Co-Pay	Ded then 20%	Ded then 30%	Ded then 50%
Well Adult/Child Care	$0	$0	Ded then 50%
Urgent Care	Ded then 20%	Ded then 30%	Ded then 50%
Emergency Room Care	Deductible then 20% coinsurance		
Pharmacy - Retail	Ded then 20%	Ded then 30%	Ded then 50%**
Pharmacy - Mail Order	Ded then 20%	Ded then 30%	Not Covered
Lifetime Maximum	Unlimited		

Note: On the HSA Compatible PPO plan, you must pay the full discounted cost of your medical and prescription drug expenses until you satisfy the annual deductible.

**One member of the family may satisfy the full family deductible.*
***For out-of-network pharmacy, you are responsible for an additional 25% of the eligible amount.*

Medical Plan Comparison

Plan Name	HMO Plan
Network	**Blue Advantage HMO Network**
Annual Deductible	$0/person $0/family
Deductible Type	N/A
Coinsurance (plan pays after deductible is met)	100%
Annual Out-of-Pocket Limit (includes copays, deductible, and coinsurance)	$1,500/person $3,000/family
Prescription Drug Out-of-Pocket Limit	$1,000/person $2,000/family
Preventive Care (includes routine physical exams, well-child care, women's preventive health services, and routine diagnostic tests)	Covered in full
Covered Services	**What You Pay After Deductible**
Physician Office Visits	$25 copay
Specialist Office Visits	$50 copay
Specialist Referral Required	Yes
Inpatient Hospital Services	$300 copay per admission
Outpatient Services	$200 copay
Urgent Care	$35 copay
Emergency Room Care	$250 copay
Pharmacy – Retail * (up to 30-day supply) • Generic • Preferred brand • Non-preferred brand • Specialty	 $10 copay $40 copay 20% to $100 max 20% to $125 max
Pharmacy – Mail Order (up to 90-day supply) • Generic • Preferred brand • Non-preferred brand	 $20 copay $80 copay 20% to $200 max

**For out-of-network pharmacy, you are responsible for an additional 25% of the eligible amount.*

Galileo Health – Your FREE Digital Medical Practice

Who is eligible:

Employees, spouses and dependents (age 0+) on the LABP Blue Choice Options PPO & HSA Compatible Plans.

Galileo Medical includes the following services FREE for PPO Plan participants, or for a $45 charge for those enrolled in the HSA Compatible Plan. As a HSA plan participant, the $45 charge will be waived once you have provided proof your annual deductible has been satisfied.

Create your account now at galileo.health/labp

Galileo: The first stop on your healthcare journey!

24/7 virtual primary and specialty care

Whether you need treatment after hours, can't get in to see your doctor, or prefer to skip the waiting room altogether, Galileo can help. You can message their doctors about sudden health issues (the flu, stomach pain) or everyday concerns (like back pain or stress). Through the app, you can access highly qualified doctors wherever you are, whenever you need it. You'll always get a fast, same-day response—at no cost to you (no copays, no deductibles).

Care navigation and advocacy – *How Can We Help?*

Galileo's Patient Support team specializes in administrative tasks that are often confusing, frustrating and time-consuming, such as:

- Requesting medical records from other doctors you see
- Insurance authorizations
- Referrals to in-network specialists
- Care coordination with multiple providers

Galileo's Advocates would be happy to help you with these tasks anytime and they're available 24/7. To get help from an Advocate, simply open the Galileo app and tap on *"Ask our patient support team"*

Mental health therapy & coaching

In addition to unlimited mental health screening, guidance and treatment, you can access up to 7 video sessions with a therapist or mental health coach at no cost via the Galileo app. Simply open the Galileo app and select *"Consult our medical experts"* and type in your concern (e.g. anxiety, depression, feeling down) and a provider will guide you.

Pediatric urgent care

Galileo provides 24/7 pediatric urgent care for your little ones, including guidance on whether in-person care is needed.

- Receive treatment for your child based on their age, symptoms, and health history.
- Find out if you need to keep your child home from school or go to the emergency room
- Text or video chat with a pediatric specialist day or night
- Skip urgent care and talk to a Galileo pediatric specialist anytime for $0.

Please note: Physicals/well-child visits, chronic condition support, and behavioral health care will be coordinated with or referred to in-person pediatricians or specialists.

To create an account for your eligible dependents under age 18, register here **galileo.health/labp**. Each eligible member needs their own account with a unique email address.

Zero

No Deductibles. No Co-Pays. No Co-Insurance. You Always Pay ZERO

Zero is available to all Blue Choice Options PPO medical plan members. HSA Compatible PPO Plan and HMO Plan members are not eligible. Zero covers services and procedures such as surgeries, x-rays, advanced imaging (MRI, CT), lab work, and much more. If your doctor refers you for a procedure or orders labwork, chances are Zero can get you that done for free. Just let your doctor know that you have Zero and would like to schedule it through them. After the doctor visit, call your Personal Health Assistant at 855.816.0001, chat online at **www.zero.health** or email **help@zero.health**. If your service or procedure is covered by Zero, they will send you a referral to the provider you choose and will set up the appointment. Providers are listed on their website at **www.zero.health**. The health plan will cover the cost, and you will pay $0.

When you need lab work, ask your doctor to send your lab orders to the nearest Quest Diagnostics location. When you arrive be sure to show your ZERO ID with the Quest Diagnostics and LabCard logos. Quest Diagnostics will then send your lab results back to your doctor. Download your ZERO ID at **my.zero.health**.

How Zero Works

Step 1
Connect with your Personal Health Assistant to see if the service or procedure you need is covered.

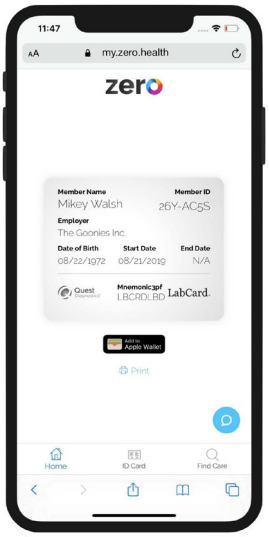
Step 2
Zero helps you find the healthcare provider that works best for you.

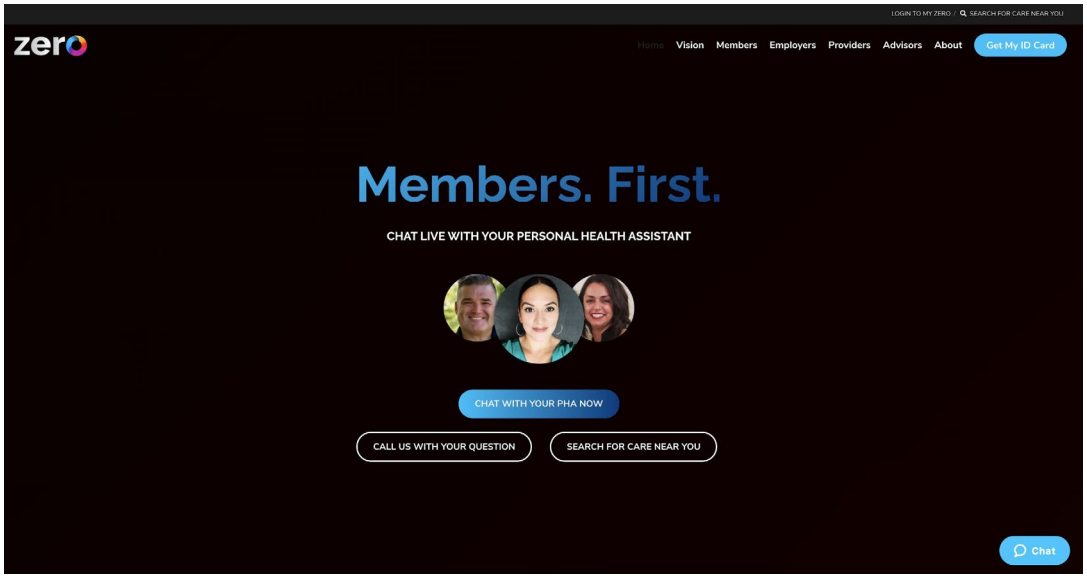
Step 3
You save money and get the care you need for $0.

Email: help@zero.health

Chat Live: www.zero.health

Call: 855-816-0001





Prescription Drug Benefits

To get the most out of your prescription drug benefits, please keep the following in mind.

Prime Therapeutics has a formulary (or preferred drug list—Performance Drug List) that is updated quarterly. We recommend that you review this list on **www.bcbsil.com** to check the cost of your prescription.

Prior Authorization. Some drugs, such as acne antibiotics, steroids, erectile dysfunction drugs, and hepatitis c medications, require prior authorization. That means you or your doctor must contact the insurance company to request approval before the drug is covered under the plan.

Step Therapy. Some medications, such as antidepressants, pain management drugs, certain cholesterol drugs, and specialty drugs for conditions like MS and rheumatoid arthritis, are subject to "step therapy." If your doctor recommends one of these drugs, you must try a "first-line" drug before the plan will cover the step therapy drug. First-line drugs are proven, cost-effective medications that are FDA-approved and treat the same condition.

Specialty Pharmacy Program. You are required to use the plan's specialty pharmacy for specialty drugs, such as injectable and infused therapies used to treat complex medical conditions such as hepatitis c, immune deficiency, hemophilia, multiple sclerosis, and rheumatoid arthritis.

No-Cost Medicines and Contraceptives. Your plan includes certain prescriptions, over-the-counter preventive medicines and contraceptives at no cost to you. Certain contraceptives for women have no member cost-share under the medical plans, as required by health care reform. Call the customer service number listed on your member ID card to find out what drugs and contraceptives are covered at no cost under your plan.

Proton Pump Inhibitors, Non-Sedating Antihistamines, Compound Medications and Over the Counter Medications. The plan will not cover brand-name PPIs (such as Nexium) any NSAs (such as Claritin) or Compound medications. Over the counter medications are also not covered under the plan.

Available to all Blue Choice Options PPO Plan and medical HMO Plan members. *The HSA Compatible PPO Plan is not eligible for The CRX International program.

Available to you on a voluntary basis is a cost saving mail order drug program for brand name prescriptions administered by CRX International. **Advantages of joining the LABPRx program administered by CRX are:**

- **$0 COPAY** for all prescriptions offered through the program
- Prescriptions shipped directly to your home with no shipping and handling costs
- No out-of-pocket expenses

Check to see if a medication is offered call CRX at 1-866-488-7874 or to view the complete formulary and enroll on-line or download an enrollment form - visit **www.crxintl.com** (WebID: LABP).

HSA Compatible PPO Plan Members

Certain generic preventive drugs are covered at 100% (deductible does not apply). Call the customer service number listed on your member ID card to find out what drugs and contraceptives are covered at no cost under your plan. The preventive program includes prescription drugs in the following categories.

- Anti-coagulant/anti-platelets
- Bowel preparation
- Breast cancer primary prevention
- Contraceptives
- Diabetes medications
- Diabetic supplies
- Fluoride supplements
- High blood pressure
- High cholesterol
- Osteoporosis
- Respiratory
- Tobacco cessation
- Vaccines

Generic drugs will always save you money. Did you know many nationwide chains such as Walmart offer generics for just $4?

Member Pay Difference. When you fill a prescription for a covered brand name drug where a generic equivalent is available, you will pay more. You will pay the copay/coinsurance amount plus the difference in cost between the brand drug and its generic equivalent.

HealthEquity®

Health Savings Account (HSA)

Employees enrolled in the HSA Compatible PPO Plan are eligible to open an HSA account administered by HealthEquity (previously known as Further). An HSA is a savings account that lets you set aside tax-favored money to pay for your qualified health care expenses, like your deductible and prescription drug costs. You are able to fund this account through pre-tax payroll deductions or by making after-tax contributions. If you make after-tax contributions, you can deduct your HSA contribution when you file your tax return. You may only access up to the balance in your HSA at the time the expense is incurred.

If you enroll in the HSA Compatible PPO plan and open an HSA with HealthEquity (previously known as Further), Lockport Area Benefit Plan will contribute money to your account per paycheck, in addition to your own personal contributions per the below chart.

Coverage Tier	Lockport Township High School Annual HSA Contribution	$1 for $1 HSA Match from Lockport Township High School (Only If You Contribute to the HSA)	Maximum Lockport Township High School Annual HSA Contribution (Assuming Full $1 for $1 Match)	2025 IRS Contribution Limits (Your Contributions + Lockport Township High School Contribution)
Employee Only	$400	Up to $300	$700	$4,300
Employee + Spouse	$1,050	Up to $550	$1,600	$8,550
Employee + Child(ren)	$1,050	Up to $550	$1,600	$8,550
Employee + Family	$1,050	Up to $950	$2,000	$8,550

Note: If you will be 55 or older, you may make an additional "catch-up" contribution of up to $1,000.

It is very important that you do not exceed the maximum contribution level. Remember that the IRS contribution limit includes your personal contributions as well as Lockport Area Benefit Plan's contribution amount. Lockport Area Benefit Plan will match your HSA contributions dollar for dollar up to the amount shown in the chart above, in addition to the base annual HSA contribution. Excess contribution dollars are subject to adverse tax consequences.

Please note: If you use the money in your HSA for something other than a qualified health care expense, you will have to pay income tax on the amount you spent, as well as an additional 20% penalty if you are younger than 65 years old. Once you turn 65, the penalty will not apply.

HSA Advantages

- The money you contribute to your HSA is exempt from all federal taxes—and it stays this way as long as you spend it on qualified health care expenses. (State income tax may still apply.)
- The money in your HSA always belongs to you. Any money you haven't spent at the end of the plan year will stay in your account—you do not have to "use it or lose it" during the plan year, as you do with a health care FSA.
- When you retire or leave Lockport Township High School, you could use the money in your HSA to pay for COBRA coverage, Medicare premiums and out-of-pocket expenses, or long-term care insurance.

Eligibility

You must not be covered by any other medical plan, unless it is also a qualified high-deductible health plan.

- You must not be enrolled in Medicare.
- You must not receive health benefits under TRICARE.
- You must not have received VA benefits within the last three months.
- You cannot be claimed as a dependent on another person's tax return, except as a spouse.
- Neither you nor your covered spouse may participate in a health care flexible spending account, unless it is a "limited FSA" used for dental and vision services only.

Medical Plan Terms You Should Know

Deductible	The dollar amount you pay for most services each calendar year before the plan will pay benefits. **Embedded Deductible.** The Blue Choice Options PPO plan will begin to pay benefits for any covered family member who satisfies the individual deductible. Once combined individual deductible amounts reach the full family level, the plan will pay benefits to all family members, even the members who have not satisfied the individual deductible. **Aggregate Deductible.** The HSA Compatible PPO plan will begin to pay benefits for any covered family member only after the entire family deductible has been satisfied. The deductible can be satisfied by one family member or multiple members. Please refer to the Medical Plan Comparison charts on pages 5-7 for your plan's family deductible type.
Coinsurance	The percentage of your medical cost you pay for most covered services. You will begin paying the coinsurance after you have met the applicable deductible.
Copay	The flat dollar amount you may pay for certain services, such as office visits and prescription drugs, when you go to a network provider.
Out-of-Pocket Limit	The maximum share of expenses you may have to pay each calendar year before the plan begins to pay at 100%. The out-of-pocket limit includes what you spend on copays, the deductible, and coinsurance.
Preferred Provider Organization (PPO)	A network of doctors and health care facilities that have agreed to provide services to plan members at discounted rates.
Medicare Reimbursement Rates	If you go to an out-of-network provider, the plan will pay benefits based on Medicare reimbursement rates for medical services in your area. Medicare's fee schedule is a national standard recognized by all providers; it is used to reimburse a significant portion of all medical claims in the United States.

Medical Plan Resources

The medical plan coverage through Blue Cross Blue Shield of Illinois (BCBSIL) includes the following resources.

Blue Access for Members

Blue Access for Members provides information about your medical plan benefits and resources to manage your health. You can request new ID cards or print temporary ID cards, check claims and claims history, view Explanation of Benefits (EOBs), and more. Go to **www.bcbsil.com** and click "Log In," then click "Register Now" if you are a new user. To register you will need your ID number on the front of your BCBSIL ID card.

24/7 Nurseline[1]

Get answers to your health questions when you need them by calling 800-299-0274 — 24 hours a day, 7 days a week. When a health problem pops up late in the day or in the middle of night, it can be hard to know how serious it is. Should you go to the emergency room? Urgent care? Or can it wait until you can see your regular doctor? Registered nurses can help you get answers to health problems you or a covered family member may be having, such as:

- Asthma flare-ups
- Back pain
- Issues from a chronic illness, like diabetes or heart problems
- Dizziness or severe headaches
- High fever
- A baby's nonstop crying
- Cuts or burns
- Sore throat
- COVID -19 concerns, symptoms and education

Cancer Support Program[1]

A cancer diagnosis can change your life forever. The BCBS oncology team will work with you to get the treatment, care and support that you and your family need. Once you have completed your treatment plan, your oncology support specialists will also help you get back to your usual routine and remind you to schedule your follow-up care. Oncology clinician support is available by calling 800-327-8497.

Fitness Program[1]

The Fitness Program offers a nationwide network of fitness centers. Membership is month to month with no long-term contract. This program is available to employees, spouses and covered dependents over age 18. Log in to Blue Access for Members and click "Fitness Program" under Quick Links to enroll.

Women's and Family Health

Whether you are pregnant or planning to get pregnant, BCBSIL members have access to a variety of tools that can help. Women's and Family Health provides app-based coaching delivered by Ovia Health®, addressing prepregnancy, pregnancy and post-pregnancy wellness[1].

Well onTarget[2]

With Well onTarget you can earn points for completing healthy activities like taking a Health Assessment, enrolling in a self-management program, joining the Fitness Program or using a fitness tracker. Redeem points with the Blue Points Program in the Shopping Mall for a variety of items. Visit **wellontarget.com** and log in using your Blue Access for Members user name and password.

Wondr Health

Wondr Health provides an anytime, anywhere online coaching program that builds behavioral skills to promote long-term weight loss and reduce the risk of metabolic syndrome. Employees, spouses and covered dependents over age 18 are eligible to apply to the program. Learn more or apply at **wondrhealth.com/BCBSIL**.

Learn to Live[1]

Help for stress, anxiety, depression, sleep problems or substance use is just one click away. Confidential online programs are available through Learn to Live at no added cost to you. This program is available to employees, spouses and covered dependents age 13 and older. Log in to Blue Access for Members, choose Wellness, then find Digital Mental Health.

[1] Not available to HMO members. For medical emergencies, call 911. These program are not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

[2] Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information. Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.

Livongo Health - Diabetes and Blood Pressure Maintenance Program

Livongo®

The Simpler Way To A Healthier You

An advanced blood glucose meter and blood pressure monitor, plus the support you need, 100% paid for by your employer.

Livongo is a program offered through Blue Cross Blue Shield of Illinois for the Blue Choice Options PPO and HSA Compatible PPO Plans. It is available to qualified members who are diagnosed with diabetes or hypertension and provides individualized coaching and monitoring of your condition. More information is available at **get.livongo.com/ILHEALTH/register**.

Join Livongo and you'll get:

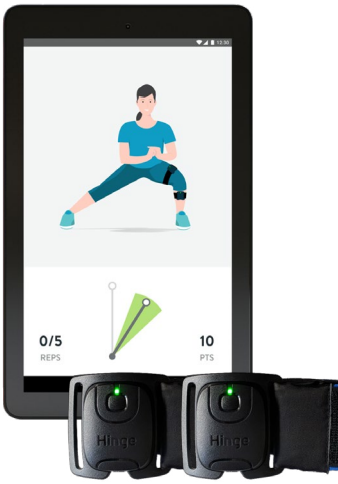
- Advanced devices to monitor your blood pressure and blood sugar
- Summary reports you can send your doctor
- Automatic uploads mean no more logbooks
- Personalized tips and articles picked just for you
- Real-time support from coaches when you need it
- Optional family alerts to keep everyone in the loop

Unlimited strips. Unlimited inspiration. It's all free for you.

Join today at **get.livongo.com/ILHEALTH/register** or call
(800) 945-4355
Use registration code: ILHEALTH

Hinge Health - Online Musculoskeletal Program

Conquer back or joint pain without drugs or surgery



As a member of Blue Cross Blue Shield of Illinois, you get access to a new innovative digital program for chronic back, knee, hip, shoulder, and neck pain at no cost to you. This program, provided by Hinge Health, includes:

- A tablet and wearable sensors
- Unlimited 1-on-1 health coaching
- Personalized exercise therapy

Over 80,000 participants have enrolled in their programs so far, and cut their pain by over 60%!*

Questions? Call the number on the back of your member ID card.

To apply, visit: **https://my.hingehealth.com/onboarding/bcbsil/registration**.
To learn more, visit: **www.hingehealth.com/resources/**.

** Source: Hinge Health 2017-2019 Outcomes Analysis*

Dental

Lockport Area Benefit Plan offers dental coverage through Delta Dental of Illinois.

How the Dental Plan Works

Whenever you need dental care, you have three options, as shown below.

Delta Dental PPO Dentists—Your Best Value! These dentists have agreed to charge Delta plan members significantly reduced rates. Delta Dental PPO has a national network of more than 78,200 dentists practicing in more than 155,500 locations.

Delta Premier Dentists. These dentists offer discounted rates for Delta plan members, but their prices are not as low as the prices in the PPO network. Premier dentists accept Delta's approved fee as payment in full—which means they won't "balance bill" you for charges that the plan does not cover.

Out-of-Network Dentists. These dentists can charge whatever they like for their services. If you have dental services performed by a non-Delta dentist, the plan will only pay benefits up to Delta Dental's approved fee. **Important:** If your non-Delta dentist charges you more than the approved fee, you will have to pay the difference.

Delta Dental PPO and Premier dentists will never charge you more than Delta Dental's approved fee.

Plan Name	Delta Dental PPO Plan		
Network	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-Network**
Calendar Year Deductible	$50/person $50/family	$50/person $50/family	$50/person $50/family
Calendar Year Maximum Benefit (the most the plan will pay in benefits for each covered person per year)	$2,000/person		$1,500/person
Preventive Services (includes oral exams, cleanings, X-rays, and fluoride treatment)	Plan pays 100%; deductible waived	Plan pays 100%; deductible waived	Plan pays 100% of the approved fee
Basic Services (includes fillings and extractions)	Plan pays 80%	Plan pays 80%	Plan pays 80% of the approved fee
Major Services (includes bridgework, crowns, and dentures)	Plan pays 80%	Plan pays 80%	Plan pays 80% of the approved fee
Orthodontic Services	Plan pays 50%, up to maximum lifetime benefit of $2,000. Child and Adult coverage is included.		

To help you make an informed choice, please refer to the plan summary for more details. Locate an in-network provider at https://www.deltadentalil.com/find-a-provider/dental/.

Vision

Lockport Area Benefit Plan offers vision coverage through VSP.

Under the VSP vision care program, you can choose between network and out-of-network providers—but you will receive a higher level of benefits, and enjoy greater convenience, if you go to a vision care provider in the VSP network. If you decide to go to an out-of-network provider, you will pay the entire bill up front, then file a claim with VSP. The plan will reimburse you for your out-of-network services up to the allowances listed below.

VSP Plan		
Eye Exams: Every 12 Months Lenses: Every 12 Months Frames: Every 24 Months Contacts (instead of glasses): Every 12 Months		
Network	**In-Network**	**Out-of-Network**
Examination	$20 copay	Plan reimburses up to $45
Frames	Up to $150 allowance; 20% of balance discount on balance	Plan reimburses up to Up to $70
Single Vision Lenses **Lined Bifocal Lenses** **Lined Trifocal Lenses** **Progressive Lenses**	Combined with exam Combined with exam Combined with exam $0 copay	Plan reimburses up to $30 - $65 Plan reimburses up to $30 - $65 Plan reimburses up to $30 - $65 Plan reimburses up to $30 - $65
Elective Contact Lenses **Medically Necessary Contact Lenses**	$150 allowance Covered in full	Plan reimburses up to $105 Plan reimburses up to $105

In addition, VSP members can receive a number of lens options, such as progressive lenses and special coatings, at a discounted price. VSP also offers a discount on laser vision correction.

Locate an in-network VSP provider at **https://www.vsp.com/eye-doctor**.

Flexible Spending Accounts (FSAs)

FSAs allow you to save money by paying certain health and dependent care expenses on a pre-tax basis. You pay no taxes on the money you put in these accounts, which means more take-home pay for you. The FSAs are administered by P&A Group.

Health Care FSA. You may contribute up to $3,300 per calendar year to pay for out-of-pocket medical, prescription drug, dental, and vision care expenses for yourself and your eligible family members—even if you do not cover your family members under the Lockport Area Benefit Plan health care plans. You can use this FSA to pay expenses like medical and dental plan deductibles and copays; orthodontia expenses not covered by your dental plan, prescription drugs, prescription glasses and contact lenses, and laser eye surgery. You may not contribute money to a Health Care FSA if you or your spouse participate in a Health Savings Account (HSA).

Dependent Care FSA. This FSA lets you set aside pre-tax money to pay for eligible dependent care expenses so that you—and your spouse, if you are married—can work. You may contribute up to $5,000 per calendar year in the FSA (if your tax filing status is "married filing jointly" or "head of household").

You must spend your FSA money on expenses you incur during the plan year, or during the 2½-month grace period, or you will lose it. You must use the money in your FSA for eligible expenses incurred from January 1, 2025 - December 31, 2025 or during the grace period (January 1, 2026 - March 15, 2026). You have until March 31, 2026 to submit reimbursement requests. Please refer to the summary plan description for the plan specific rules.

FSA Debit Card

You will receive a debit card that you can use to access your FSA funds for eligible expenses. This card works like a bank debit card—just swipe it when you make your purchase and the money will automatically be deducted from your account. Having your expenses directly debited from your FSA saves you time and improves your cash flow. You may be asked to document your FSA expenses, so be sure to save your receipts!

Basic Life and AD&D Insurance

All eligible employees are automatically covered by the group life insurance and accidental death and dismemberment (AD&D) insurance plans. Lockport Area Benefit Plan pays the full cost of these plans, which are insured by Mutual of Omaha. Benefits are payable to your designated beneficiary.

Company-Paid Life Insurance

Refer to the Mutual of Omaha booklet for specifics on your life insurance benefit.

Company-Paid AD&D Insurance

This plan pays an additional benefit if you die as a result of a covered accident. Benefits are also payable if you suffer certain severe injuries in an accident, including loss of limb, sight, or paralysis.

Your company-paid AD&D benefit is equal to your life insurance benefit.

Your coverage amount will reduce when you get older; see your Certificate of Insurance for details.

Supplemental Life and AD&D Insurance

The Supplemental Life and AD&D insurance plan lets you buy coverage in addition to the Life and AD&D insurance provided by Lockport Area Benefit Plan. You will pay the full cost of your insurance through payroll deductions.

If you purchase coverage for yourself, you may also purchase coverage for your family members.

	Coverage for You	Coverage for Your Spouse	Coverage for Your Children
Maximum Benefit Amount	7 times annual salary, up to $500,000	100% of employee's benefit, up to $500,000	100% of employee's benefit, up to $10,000
Guaranteed Issue Amount*	7 times annual salary, up to $150,000	100% of employee's benefit, up to $40,000	100% of employee's benefit

**When you first become eligible for Lockport Area Benefit Plan's benefits program, you may purchase life insurance coverage up to the Guaranteed Issue (GI) amount without providing evidence of good health. You will have to submit evidence of good health for any coverage over the GI amount and will not be covered for the higher value until you receive approval from Mutual of Omaha.*

If you enroll in the Supplemental life insurance plan when you first become eligible, you may increase your coverage each open enrollment by $10,000—up to the Guaranteed Issue amount—without providing evidence of good health. If you do not enroll when you are first eligible and later wish to purchase any amount of coverage during open enrollment, you will have to provide evidence of good health.

Your Supplemental life insurance coverage automatically comes with an equal amount of AD&D coverage.

Employee Assistance Program

We all need help with life's challenges now and then. Whether it's a difficult situation affecting your home life or stress interfering with your work, the employee assistance program (EAP) is there for you and your immediate family members 24 hours a day, seven days a week.

The EAP is provided by Lockport Area Benefit Plan at no cost to you and is administered by Mutual of Omaha.

The EAP provides free, strictly confidential counseling to help you resolve a wide range of personal issues, including:

- Stress and depression
- Life transitions
- Grief and loss
- Parenting and child care
- Elder care referrals
- Domestic violence
- Workplace conflict
- Work/life balance
- Addiction and recovery
- Financial issues
- Legal assistance

Call the EAP whenever you need help. Your call will be handled confidentially by a professional counselor: 800-316-2796.

Additional Benefit Plans

Lockport Area Benefit Plan offers valuable voluntary benefit plans through Aflac, to give you and your family members additional financial protection in the event of an accident, serious illness, or loss. If you enroll in one of these individual plans, you can keep your coverage if you leave Lockport Area Benefit Plan or retire.

Plans offered by Aflac include:

- *Personal Income Disability Protector*
- *Personal Accident Indemnity Plan*
- *Hospital Protector*
- *Cancer Indemnity Insurance*
- *Critical Care Plan*

Please see your Aflac materials for more information.

Mutual of Omaha offers the following benefits:

- *Identity Theft Recovery Assistance.* If your identity is compromised, the most important thing to do is respond quickly. We assist you by:
  - Connecting you to the fraud departments at your bank(s) and credit card companies
  - Facilitating access to credit bureaus and obtaining a complimentary credit report
  - Guiding you in contacting federal government and local law enforcement agencies and filing reports and complaints. Call 800-856-9947 or log onto **www.mutualofomaha.com**.

- *Travel Assistance.* The Mutual of Omaha life insurance plan includes 24-hour assistance for you and your family when you travel at least 100 miles from home for business or pleasure. Benefits include pre-departure information, emergency medical services, and a broad range of other personal services. Call 800-856-9947 or log onto **www.mutualofomaha.com**.

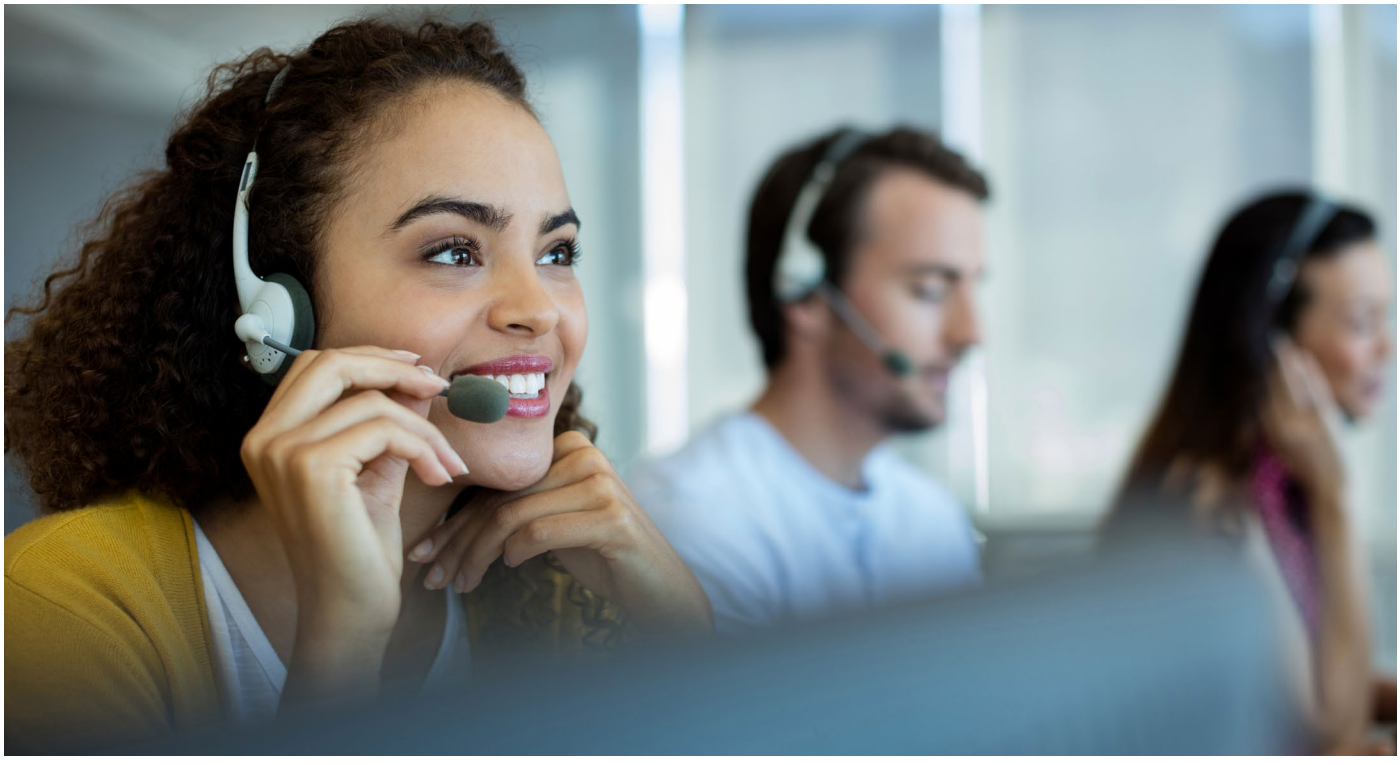
Will Preparation Services:

- Epoq provides online will preparation services at no cost to you. It's a benefit that helps you protect what's important to you.
- Create your will at **www.willprepservices.com** and use the code MUTUALWILLS to register.
  - Answer simple questions and watch your document happen in real time
  - Download and print any document instantly
  - Update information with any major life change.

Contact Information

Benefit Plan	Carrier/Administrator	Group Number	Phone	Website
Medical Blue Choice Options PPO Plan	Blue Cross Blue Shield of Illinois	272752	800-810-2583	www.bcbsil.com
Medical HSA Compatible PPO Plan	Blue Cross Blue Shield of Illinois	324631	800-810-2583	www.bcbsil.com
Medical HMO Plan	Blue Cross Blue Shield of Illinois	B06641	800-810-2583	www.bcbsil.com
Specialty Pharmacy	Express Scripts Pharmacy		800-810-2583	
Digital Primary Care	Galileo	n/a	855-542-9848	support@galileohealth.com
Dental PPO Plan	Delta Dental of Illinois	11638	800-323-1743	www.deltadentalil.com
Vision Plan	VSP	12294428	800-877-7195	www.vsp.com
Health Savings Account	HealthEquity	201197	866-711-4860	www.healthequity.com
Flexible Spending Account	P&A Group		800-688-2611	www.padmin.com
Supplemental Life and AD&D Insurance	Mutual of Omaha	GLUG-B6VC	800-316-2796	www.mutualofomaha.com
Employee Assistance Program	Mutual of Omaha	Lockport Area Benefit Plan	800-316-2796	www.mutualofomaha.com/eap
Identity Theft Protection	Mutual of Omaha/AXA		800-856-9947	www.mutualofomaha.com
Travel Assistance	Mutual of Omaha/AXA		800-856-9947	www.mutualofomaha.com
Additional Benefit Plans	Aflac		800-922-3522	www.aflac.com

Most insurance companies now offer free mobile apps to help manage your care on the go. Visit their website for details.



2025 Annual Notices For Group Health Plan Benefits

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires we provide you with notice of certain legal rights that you may have and legal obligations that apply to the Lockport Area Benefit Plan Group Health Plan. These rights and obligations are described in more detail in the enclosed notices.

You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write or call Susan Mead at **smead@lths.org**.

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan, which are available by contacting the Human Resources Department.

Women's Health and Cancer Rights Act (WHCRA) Notice

Enrollment Notice:

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. Therefore, the deductibles and coinsurance apply for the: BCBSIL BCO PPO, HMO, & HSA PPO Plans.

If you would like more information on WHCRA benefits, call your plan administrator, Susan Mead at 815-588-8120.

Annual Notice:

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator, Susan Mead at 815-588-8120 for more information.

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).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

As of August 2022, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon Texas, Virginia, Washington.

As of August 2022, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the US Dept. of Health & Human Services at

1-877-696-6775 or your State Insurance Commissioner.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Michelle's Law

When a dependent child over the age of 26 loses student status under the eligibility policy of Lockport Area Benefit Plan group health plan group health plan coverage, as a result of a medically necessary leave of absence from a post-secondary educational institution, the Lockport Area Benefit Plan group health plan group health plan will continue to provide coverage during the leave of absence for the earlier end date of up to one year, or until coverage would otherwise terminate under the Lockport Area Benefit Plan group health plan group health plan.

To maintain eligibility continue coverage as a dependent during such leave of absence:

- The Lockport Area Benefit Plan group health plan group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- The dependent must be established as a disabled dependent as defined by the medical carriers. Please refer to the plan's SPD. To access your SPDs, contact Susan Mead at **smead@lths.org**.

To obtain additional information, please contact: Susan Mead at **smead@lths.org.**

Notice of HIPAA Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact:

Susan Mead
1323 E. 7th Street, Lockport, IL 60441
815-588-8120

Important Notice from Lockport Township High School District 205 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 Lockport Township High School District 205 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Lockport Township High School District 205 has determined that the prescription drug coverage offered by the Lockport Township High School District 205 Employee Benefit Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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 coverage may be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

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 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 changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	July 1 2025
Name of Entity/Sender:	Lockport Township High School District 205
Contact/Office:	Susan Mead/Human Resources
Address:	1323 E. 7th Street, Lockport, IL 60441
Phone Number:	815-588-8120

Notice of HIPAA 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 the Lockport Township High School District 205 Health 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. It is effective on July 1 2025.

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. Lockport Township High School District 205 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 Lockport Township High School District 205 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 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:

Susan Mead
Human Resources Department
Lockport Township High School District 205
1323 E. 7th Street, Lockport, IL 60441
815-588-8120
smead@lths.org

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** for 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 Patient Protections

BCBSIL HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, BCBSIL HMO 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 BCBS of IL at **www.bcbsil.com**.

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

You do not need prior authorization from BCBSIL HMO 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 BCBS of IL at **www.bcbsil.com**.

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

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, 2024. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid **Website:** http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	**CALIFORNIA – Medicaid** Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322, Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	**FLORIDA – Medicaid** **Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	**INDIANA – Medicaid** Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/, http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864, Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	**KANSAS – Medicaid** **Website:** https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	**LOUISIANA – Medicaid** **Website:** www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740, TTY: Maine relay 711	**MASSACHUSETTS – Medicaid and CHIP** **Website:** https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840, TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid **Website:** https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	**MISSOURI – Medicaid** **Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid **Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084, Email: HHSHIPPProgram@mt.gov	**NEBRASKA – Medicaid** **Website:** http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633, Lincoln: 402-473-7000, Omaha: 402-595-1178
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	**NEW HAMPSHIRE – Medicaid** **Website:** https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	**NEW YORK – Medicaid** **Website:** https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid **Website:** https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	**NORTH DAKOTA – Medicaid** **Website:** https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP **Website:** http://www.insureoklahoma.org Phone: 1-888-365-3742	**OREGON – Medicaid and CHIP** **Website:** http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP **Website:** https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	**RHODE ISLAND – Medicaid and CHIP** **Website:** http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid **Website:** https://www.scdhhs.gov, Phone: 1-888-549-0820	**SOUTH DAKOTA - Medicaid** **Website:** http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid **Website:** Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	**UTAH – Medicaid and CHIP** Utah's Premium Partnership for Health Insurance (UPP) **Website:** https://medicaid.utah.gov/upp/ Email: upp@utah.gov, Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid **Website:** Health Insurance Premium Payment (HIPP) Program	Department of Vermont Health Access Phone: 1-800-250-8427	**VIRGINIA – Medicaid and CHIP** **Website:** https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid **Website:** https://www.hca.wa.gov/ Phone: 1-800-562-3022	**WEST VIRGINIA – Medicaid and CHIP** **Website:** https://dhhr.wv.gov/bms/, http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP **Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	**WYOMING – Medicaid** **Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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 is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to 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 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

Susan Mead, Benefits Coordinator

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.

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 **Lockport Township High School District 205**			4. Employer Identification Number (EIN) **Verify with HR**
5. Employer address **1323 East Seventh Street**			6. Employer phone number **815-588-8120**
7. City **Lockport**		8. State **IL**	9. ZIP code **60441**
10. Who can we contact about employee health coverage at this job? **Susan Mead**			
11. Phone number (if different from above)	12. Email address **smead@lths.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:
  - ☐ Some employees. Eligible employees are:

    Contact your HR administrator for details
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:

    Contact your HR administrator for details
  - ☐ 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?**

☐ **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? _____ (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*?
☐ 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? $_____
b. How often? ☐ Weekly ☐ 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?_____
☐ 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)